

MONTANA LEGISLATIVE HISTORY

Chapter 413 19 1997

Bill H _____ S 365

Original bill & history ☒ c

H. Committee on Human Serv. & Aging

Hearing Date(s) h 3/21 _____ c

ex 3/27 _____ c

_____ c

_____ c

Date Out _____ c

S. Committee on Pub Health Welf & Svc

Hearing Date(s) h 2/19 _____ c

ex 2/22 _____ c

_____ c

_____ c

✓ Proposed Amendments GOV
4/21

Did this bill originate in an interim committee? _____ Yes _____ No

Committee _____

Report _____

LEGISLATIVE HISTORIES SINCE 1997

The scope and depth of legislative committee minutes varies by year and by committee. If you would like additional information about a hearing, you may want to determine whether the hearing was recorded. In addition, some recent floor debates were also recorded. For information on accessing or purchasing these recordings, contact the Historical Society Archives at 406-444-4774.

If you have concerns regarding the format of the enclosed committee minutes or the recordings of the hearings, it is suggested that you contact your state legislators.

SB 362 INTRODUCED BY GAGE

LC1091 DRAFTER: MARTIN

REVISE THE DISTRIBUTION OF OIL AND NATURAL GAS PRODUCTION
TAXES ON POST-1985 WELLS TO COUNTIES, SCHOOL DISTRICTS,
SCHOOL EQUALIZATION, AND THE UNIVERSITY SYSTEM

2/14 INTRODUCED
2/14 FIRST READING
2/14 REFERRED TO TAXATION
2/14 FISCAL NOTE REQUESTED (EXTENSION GRANTED FOR
COMPLETION)
2/21 HEARING
2/25 FISCAL NOTE RECEIVED
2/25 FISCAL NOTE PRINTED
3/18 TABLED IN COMMITTEE
4/05 MISSED DEADLINE FOR 71ST DAY TRANSMITTAL
DIED IN COMMITTEE

SB 363 INTRODUCED BY GROSFIELD

LC0824 DRAFTER: WILLIAMS

ALLOW EMERGENCY GROUND WATER USE TO BENEFIT THE FISHERY
RESOURCE

2/14 INTRODUCED
2/14 FIRST READING
2/14 REFERRED TO NATURAL RESOURCES
2/14 FISCAL NOTE REQUESTED
2/19 HEARING
2/19 FISCAL NOTE RECEIVED
2/20 FISCAL NOTE PRINTED
2/24 COMMITTEE REPORT—BILL PASSED AS AMENDED
2/25 2ND READING DO PASS AS AMENDED MOTION FAILED 19 31

SB 364 INTRODUCED BY BARTLETT, ET AL.

LC0594 DRAFTER: MCCLURE

ESTABLISH THE LIVEABLE WAGE FOR FAMILIES ACT

2/14 INTRODUCED
2/14 FIRST READING
2/14 REFERRED TO LABOR & EMPLOYMENT RELATIONS
2/14 FISCAL NOTE REQUESTED
2/19 FISCAL NOTE RECEIVED
2/20 HEARING
2/20 FISCAL NOTE PRINTED
2/21 TABLED IN COMMITTEE
3/03 MISSED DEADLINE FOR 45TH DAY TRANSMITTAL
DIED IN COMMITTEE

SB 365 INTRODUCED BY BENEDICT, ET AL.

LC1206 DRAFTER: NISS

PROVIDE FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO
OFFER MANAGED CARE PLANS

2/14 INTRODUCED
2/14 FIRST READING
2/14 REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY
2/14 FISCAL NOTE REQUESTED
2/19 HEARING
2/20 FISCAL NOTE RECEIVED
2/20 FISCAL NOTE PRINTED
2/22 COMMITTEE REPORT—BILL PASSED AS AMENDED
2/25 2ND READING PASSED 50 0
2/26 3RD READING PASSED 49 0

	TRANSMITTED TO HOUSE		
3/03	FIRST READING		
3/03	REFERRED TO HUMAN SERVICES & AGING		
3/21	HEARING		
4/03	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/04	2ND READING CONCURRED	89	11
4/05	3RD READING CONCURRED	86	13
	RETURNED TO SENATE WITH AMENDMENTS		
4/09	2ND READING AMENDMENTS CONCURRED	31	18
4/10	3RD READING CONCURRED AS AMENDED	50	0
4/15	SIGNED BY PRESIDENT		
4/16	SIGNED BY SPEAKER		
4/16	TRANSMITTED TO GOVERNOR		
4/21	RETURNED TO SENATE WITH GOVERNOR'S PROPOSED AMENDMENTS		
4/21	2ND READING GOVERNOR'S PROPOSED AMENDMENTS CONCURRED	79	11
4/21	2ND READING GOVERNOR'S PROPOSED AMENDMENTS CONCURRED	48	0
	HOUSE		
4/21	3RD READING GOVERNOR'S PROPOSED AMENDMENTS CONCURRED	87	12
4/21	3RD READING GOVERNOR'S PROPOSED AMENDMENTS CONCURRED	48	2
4/24	SIGNED BY PRESIDENT		
4/24	SIGNED BY SPEAKER		
4/24	TRANSMITTED TO GOVERNOR		
4/28	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 413		
	EFFECTIVE DATE: 04/28/97—SECTIONS 12, 22 & 30-33		
	EFFECTIVE DATE: 01/01/98—SECTIONS 1-11, 14, 16 & 17		
	EFFECTIVE DATE: 10/01/99—SECTIONS 13, 15, 18-21 & 23-29		

SB 366 INTRODUCED BY BARTLETT, ET AL. LC0754 DRAFTER: HEFFELFINGER
 ESTABLISH THE MONTANA VOTER CONTACT AND ELECTORAL REFORM
 ACT OF 1997 FOR CONGRESSIONAL CANDIDATES

2/14	FISCAL NOTE REQUESTED		
2/15	INTRODUCED		
2/15	FIRST READING		
2/15	REFERRED TO STATE ADMINISTRATION		
2/20	HEARING		
2/20	FISCAL NOTE RECEIVED		
2/20	FISCAL NOTE PRINTED		
2/21	TABLED IN COMMITTEE		
2/24	MOTION FAILED TO TAKE FROM COMMITTEE & PLACE ON 2ND READING	20	30
3/03	MISSED DEADLINE FOR 45TH DAY TRANSMITTAL DIED IN COMMITTEE		

SB 367 INTRODUCED BY BARTLETT, ET AL. LC0763 DRAFTER: HEFFELFINGER
 ESTABLISH THE REASONABLE SPENDING FOR RESPONSIVE
 GOVERNMENT ACT OF 1997

2/14	FISCAL NOTE REQUESTED		
2/15	INTRODUCED		
2/15	FIRST READING		
2/15	REFERRED TO STATE ADMINISTRATION		
2/20	HEARING		
2/20	FISCAL NOTE RECEIVED		

BILL NO. 365

INTRODUCED BY

BENEDICT HARGREAVEJOHN HARPMERCER

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of national accrediting organizations.

In order to promote uniformity of standards applicable to all managed care plans, state quality assurance standards for small managed care plans must consist of standards that are at least the equivalent of health plan employer data and information standards. Any other standards adopted must be appropriate for quality assurance in Montana.

The department may refer reports of noncompliance by a health carrier to the commissioner for corrective action. Under the department's rulemaking authority, the department shall specify network

adequacy and quality assurance review processes.

[Section 19] designates the department of public health and human services as the place for insurance carriers to file documents related to managed care provider network adequacy and quality assurance. The department shall adopt rules establishing procedures for filing these documents and shall adopt rules specifying processes for amending or withdrawing documents already filed that relate to network adequacy and quality assurance.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-1703, MCA, is amended to read:

"33-22-1703. Definitions. As used in this part, the following definitions apply:

(1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

~~(2) "Emergency services" means services provided after suffering an accidental bodily injury or the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that without immediate medical attention the subscriber or insured could reasonably expect that:~~

~~(a) the subscriber's or insured's health would be in serious jeopardy;~~

~~(b) the subscriber's or insured's bodily functions would be seriously impaired; or~~

~~(c) a bodily organ or part would be seriously damaged.~~ health care items or services furnished or required to evaluate and treat an emergency medical condition.

~~(2)(3)~~ (3) "Health benefit plan" means the health insurance policy or subscriber arrangement between the insured or subscriber and the health care insurer that defines the covered services and benefit levels available.

~~(3)(4)~~ (4) "Health care insurer" means:

(a) an insurer that provides disability insurance as defined in 33-1-207;

(b) a health service corporation as defined in 33-30-101;

(c) ~~a health maintenance organization as defined in 33-31-102;~~

~~(d)~~ a fraternal benefit society as described in 33-7-105; or

~~(e)~~(d) any other entity regulated by the commissioner that provides health coverage except a health maintenance organization.

~~(4)~~(5) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization or services provided under Title 33, chapter 22, part 7.

~~(5)~~(6) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

~~(6)~~(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

~~(7)~~(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

~~(8)~~(9) "Provider" means an individual or entity licensed or legally authorized to provide health care services or services covered within Title 33, chapter 22, part 7.

~~(9)~~(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

Section 2. Section 33-22-1707, MCA, is amended to read:

"33-22-1707. Rules. The commissioner ~~shall promulgate~~ may adopt rules necessary to implement the provisions of this part."

Section 3. Section 33-31-102, MCA, is amended to read:

"33-31-102. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply: ,

(1) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

- 1 (d) medical treatment and referral services;
- 2 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant
- 3 to 33-31-301(3)(e);
- 4 (f) care and treatment of mental illness, alcoholism, and drug addiction;
- 5 (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;
- 6 (h) preventive health services, including:
- 7 (i) immunizations;
- 8 (ii) well-child care from birth;
- 9 (iii) periodic health evaluations for adults;
- 10 (iv) voluntary family planning services;
- 11 (v) infertility services; and
- 12 (vi) children's eye and ear examinations conducted to determine the need for vision and hearing
- 13 correction;
- 14 (i) minimum mammography examination, as defined in 33-22-132; and
- 15 (j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under
- 16 the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels
- 17 of phenylalanine and adequate nutritional status.
- 18 (2) "Commissioner" means the commissioner of insurance of the state of Montana.
- 19 (3) "Enrollee" means a person:
- 20 (a) who enrolls in or contracts with a health maintenance organization;
- 21 (b) on whose behalf a contract is made with a health maintenance organization to receive health
- 22 care services; or
- 23 (c) on whose behalf the health maintenance organization contracts to receive health care services.
- 24 (4) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee
- 25 setting forth the coverage to which the enrollee is entitled.
- 26 (5) "Health care services" means:
- 27 (a) the services included in furnishing medical or dental care to a person;
- 28 (b) the services included in hospitalizing a person;
- 29 (c) the services incident to furnishing medical or dental care or hospitalization; or
- 30 (d) the services included in furnishing to a person other services for the purpose of preventing,

1 alleviating, curing, or healing illness, injury, or physical disability.

2 (6) "Health care services agreement" means an agreement for health care services between a
3 health maintenance organization and an enrollee.

4 (7) "Health maintenance organization" means a person who provides or arranges for basic health
5 care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees
6 or through contractual or other arrangements with a provider or a group of providers. This subsection does
7 not limit methods of provider payments made by health maintenance organizations.

8 (8) "Insurance producer" means an individual, partnership, or corporation appointed or authorized
9 by a health maintenance organization to solicit applications for health care services agreements on its
10 behalf.

11 (9) "Person" means:

12 (a) an individual;

13 (b) a group of individuals;

14 (c) an insurer, as defined in 33-1-201;

15 (d) a health service corporation, as defined in 33-30-101;

16 (e) a corporation, partnership, facility, association, or trust; or

17 (f) an institution of a governmental unit of any state licensed by that state to provide health care,
18 including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

19 (10) "Plan" means a health maintenance organization operated by an insurer or health service
20 corporation as an integral part of the corporation and not as a subsidiary.

21 (11) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist,
22 osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist,
23 ~~or nurse specialist~~ advanced practice registered nurse as specifically listed in 37-8-202 who treats any
24 illness or injury within the scope and limitations of ~~his~~ the provider's practice or any other person who is
25 licensed or otherwise authorized in this state to furnish health care services.

26 (12) "Uncovered expenditures" mean the costs of health care services that are covered by a health
27 maintenance organization and for which an enrollee is liable if the health maintenance organization becomes
28 insolvent."

29
30 **Section 4.** Section 33-31-111, MCA, is amended to read:

1 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise
2 provided in this chapter, the insurance or health service corporation laws do not apply to any health
3 maintenance organization authorized to transact business under this chapter. This provision does not apply
4 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
5 corporation laws of this state except with respect to its health maintenance organization activities
6 authorized and regulated pursuant to this chapter.

7 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
8 or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or
9 advertising by health professionals.

10 (3) A health maintenance organization authorized under this chapter ~~may not be considered to be~~
11 is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

12 (4) ~~The provisions of this~~ This chapter ~~de~~ does not exempt a health maintenance organization from
13 the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

14 (5) ~~The provisions of this~~ This section ~~de~~ does not exempt a health maintenance organization from
15 material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance
16 organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

17 (6) This section does not exempt a health maintenance organization from network adequacy and
18 quality assurance requirements provided under [sections 8 through 29]."

19
20 **Section 5.** Section 33-31-211, MCA, is amended to read:

21 **"33-31-211. Annual statement statements -- revocation for failure to file -- penalty for false**
22 **swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized
23 health maintenance organization shall annually on or before March 1 file with the commissioner a full and
24 true statement of its financial condition, transactions, and affairs as of the preceding December 31. The
25 statement must be in the general form and content required by the commissioner. The statement must be
26 verified by the oath of at least two principal officers of the health maintenance organization. The
27 commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance
28 organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file
29 on or before June 1 an audited financial statement.

30 (2) At the time of filing ~~its~~ the annual statement required by March 1, the health maintenance

organization shall pay the commissioner the fee for filing ~~its~~ the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed \$5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he considers~~ considered reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ required of the commissioner duties under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

Section 6. Section 33-31-216, MCA, is amended to read:

"33-31-216. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation ~~must be the greater of:~~

~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~

~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~

~~(c) \$100,000~~ is \$200,000.

(3) At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on October 1, 1987, shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

1 (b) ~~\$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987.~~
2 ~~In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its~~
3 ~~estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must~~
4 ~~be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and~~
5 ~~subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual~~
6 ~~uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably~~
7 ~~reflect the preceding year's operating experience and delivery arrangements.~~

8 (5) The commissioner may ~~in his discretion~~ waive any of the deposit requirements set forth in
9 subsections (1) through (4) whenever ~~he~~ the commissioner is satisfied that:

10 (a) the health maintenance organization has sufficient net worth and an adequate history of
11 generating net income to ~~assure~~ ensure its financial viability for the next year;

12 (b) the health maintenance organization's performance and obligations are guaranteed by an
13 organization with sufficient net worth and an adequate history of generating net income; or

14 (c) the health maintenance organization's assets or its contracts with insurers, health service
15 corporations, governments, or other organizations are reasonably sufficient to assure the performance of
16 its obligations.

17 (6) When a health maintenance organization achieves a net worth not including land, buildings, and
18 equipment of at least \$1 million or achieves a net worth including organization-related land, buildings, and
19 equipment of at least \$5 million the annual deposit requirement under subsection (3) does not apply. The
20 annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the
21 total amount of the accumulated deposit is greater than the capital requirement for the formation or
22 admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing
23 organization that has been in operation for at least 5 years and has a net worth not including land,
24 buildings, and equipment of at least \$1 million or that has been in operation for at least 10 years and has
25 a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual
26 deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring
27 more than one health maintenance organization, however, the net worth requirement is increased by a
28 multiple equal to the number of ~~such~~ those health maintenance organizations. This requirement to maintain
29 a deposit in excess of the deposit required of a disability insurer does not apply during any time that the
30 guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at

1 least equal to the capital and surplus requirements for a disability insurer.

2 (7) All income from deposits belongs to the depositing health maintenance organization and must
3 be paid to it as it becomes available. A health maintenance organization that has made a securities deposit
4 may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any
5 combination of cash or securities of equal amount and value. A health maintenance organization may not
6 substitute securities without prior approval by the commissioner.

7 (8) In any year in which an annual deposit is not required of a health maintenance organization,
8 at the health maintenance organization's request, the commissioner shall reduce the previously accumulated
9 deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows the health
10 maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth
11 no longer supports a reduction of its required deposit, the health maintenance organization shall immediately
12 redeposit \$100,000 for each \$250,000 of reduction in net worth, ~~except that its.~~ However, the health
13 maintenance organization's total deposit may not be required to exceed the maximum required under this
14 section.

15 (9) Unless it is operated by an insurer or a health service corporation as a plan, each health
16 maintenance organization ~~shall~~ must have a minimum capital of at least \$200,000 in addition to any deposit
17 requirements under this section. The capital account must be in excess of any accrued liabilities and be in
18 the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

19 (10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

20 (a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

21 (b) enrollees will be entitled to similar alternate insurance coverage that does not contain any
22 medical underwriting or preexisting limitation requirements."
23

24 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
25 organization may not increase a premium for an individual's or an individual's group health care services
26 agreement more frequently than once during a 12-month period unless failure to increase the premium more
27 frequently than once during the 12-month period would:

28 (a) place the health maintenance organization in violation of the laws of this state; or

29 (b) cause the financial impairment of the health maintenance organization to the extent that further
30 transaction of insurance by the health maintenance organization would injure or be hazardous to its

1 enrollees or to the public.

2 (2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, by
3 a court decision, by a state rule, or by a federal regulation.

4
5 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
6 Plan Network Adequacy and Quality Assurance Act".

7
8 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

9 (1) establish standards for the creation and maintenance of networks by health carriers offering
10 managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered
11 under a managed care plan by establishing requirements for written agreements between health carriers
12 offering managed care plans and participating providers regarding the standards, terms, and provisions
13 under which the participating provider will provide services to covered persons;

14 (2) provide for the implementation of state network adequacy and quality assurance standards in
15 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for
16 detecting and reporting violations of those standards to the commissioner;

17 (3) establish minimum criteria for the quality assessment activities of a health carrier issuing a
18 closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted
19 by rule;

20 (4) enable health carriers to evaluate, maintain, and improve the quality of health care services
21 provided to covered persons; and

22 (5) provide a streamlined and simplified process by which managed care network adequacy and
23 quality assurance programs may be monitored for compliance. It is not the purpose or intent of [sections
24 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
25 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
26 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

27
28 **NEW SECTION. Section 10. Definitions.** As used in [sections 8 through 29], the following
29 definitions apply:

30 (1) "Closed plan" means a managed care plan that requires covered persons to use only

1 participating providers under the terms of the managed care plan.

2 (2) "Combination plan" means an open plan with a closed component.

3 (3) "Covered benefits" means those health care services to which a covered person is entitled
4 under the terms of a health benefit plan.

5 (4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating
6 in a health benefit plan.

7 (5) "Department" means the department of public health and human services established in
8 2-15-2201.

9 (6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient
10 severity, including severe pain, that the absence of immediate medical attention could reasonably be
11 expected to result in any of the following:

12 (a) the covered person's health would be in serious jeopardy;

13 (b) the covered person's bodily functions would be seriously impaired; or

14 (c) a bodily organ or part would be seriously damaged.

15 (7) "Emergency services" means health care items and services furnished or required to evaluate
16 and treat an emergency medical condition.

17 (8) "Facility" means an institution providing health care services or a health care setting, including
18 but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient
19 center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center,
20 a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

21 (9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered,
22 or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health
23 care services.

24 (10) "Health care professional" means a physician or other health care practitioner licensed,
25 accredited, or certified pursuant to the laws of this state to perform specified health care services
26 consistent with state law.

27 (11) "Health care provider" or "provider" means a health care professional or a facility.

28 (12) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief
29 of a health condition, illness, injury, or disease.

30 (13) "Health carrier" means an entity subject to the insurance laws and rules of this state that

1 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or
2 reimburse any of the costs of health care services, including a disability insurer, health maintenance
3 organization, or health service corporation or another entity providing a health benefit plan.

4 (14) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract
5 between a health carrier and a provider or between a health carrier and a network.

6 (15) "Managed care plan" means a health benefit plan that either requires or creates incentives,
7 including financial incentives, for a covered person to use health care providers managed, owned, under
8 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
9 networks operated in a fee-for-service indemnity environment.

10 (16) "Medically necessary" means services or supplies that are necessary and appropriate for the
11 treatment of a covered person's emergency medical condition or for the preventive care of a covered person
12 according to accepted standards of medical practice.

13 (17) "Network" means the group of participating providers that provides health care services to
14 a managed care plan.

15 (18) "Open plan" means a managed care plan other than a closed plan that provides incentives,
16 including financial incentives, for covered persons to use participating providers under the terms of the
17 managed care plan.

18 (19) "Participating provider" means a provider who, under a contract with a health carrier or with
19 the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services
20 to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or
21 deductibles, directly or indirectly from the health carrier.

22 (20) "Primary care professional" means a participating health care professional designated by the
23 health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and
24 who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision
25 of health care services rendered to the covered person.

26 (21) "Quality assessment" means the measurement and evaluation of the quality and outcomes
27 of medical care provided to individuals, groups, or populations.

28 (22) "Quality assurance" means quality assessment and quality improvement.

29 (23) "Quality improvement" means an effort to improve the processes and outcomes related to the
30 provision of health care services within a health plan.

1 **NEW SECTION.** **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
2 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
3 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
4 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
5 medicaid recipients.

6
7 **NEW SECTION.** **Section 12. Department -- general powers and duties -- rulemaking.** (1) The
8 department shall:

9 (a) adopt rules pursuant to the Montana Administrative Procedure Act establishing minimum state
10 standards for network adequacy and quality assurance and procedures for ensuring compliance with those
11 standards; and

12 (b) recommend action to the commissioner against a health carrier whose managed care plan does
13 not comply with standards for network adequacy and quality assurance adopted by the department.

14 (2) Quality assurance standards adopted by the department must consist of some but not all of the
15 health plan employer data and information standards. The department shall select and adopt only standards
16 appropriate for quality assurance in Montana.

17 (3) The state may contract, through a competitive bidding process, for the development of network
18 adequacy and quality assurance standards.

19
20 **NEW SECTION.** **Section 13. Network adequacy -- standards -- access plan required.** (1) A health
21 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
22 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
23 Sufficiency in number and type of provider is determined in accordance with the requirements of this
24 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
25 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
26 may include but are not limited to:

- 27 (a) a ratio of specialty care providers to covered persons;
28 (b) a ratio of primary care providers to covered persons;
29 (c) geographic accessibility;
30 (d) waiting times for appointments with participating providers;

1 (e) hours of operation; or

2 (f) the volume of technological and specialty services available to serve the needs of covered
3 persons requiring technologically advanced or specialty care.

4 (2) Whenever a health carrier has an insufficient number or type of participating providers to
5 provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered
6 benefit at no greater cost to the covered person than if the covered benefit were obtained from participating
7 providers or shall make other arrangements acceptable to the department.

8 (3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable
9 proximity of participating providers to the businesses or personal residences of covered persons. In
10 determining whether a health carrier has complied with this requirement, consideration must be given to
11 the relative availability of health care providers in the service area under consideration.

12 (4) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial
13 capability, and legal authority of its providers to furnish all covered benefits to covered persons.

14 (5) A health carrier offering a managed care plan in this state on October 1, 1998, shall file with
15 the department on October 1, 1998, an access plan complying with subsection (7) and the rules of the
16 department. A health carrier offering a managed care plan in this state for the first time after October 1,
17 1998, shall file with the department an access plan meeting the requirements of subsection (7) and the
18 rules of the department before offering the managed care plan. A plan must be filed with the department
19 in a manner and form complying with the rules of the department. A health carrier shall file any subsequent
20 material changes in its access plan with the department within 30 days of implementation of the change.

21 (6) A health carrier may request the department to designate parts of its access plan as proprietary
22 or competitive information, and when designated, that part may not be made public. For the purposes of
23 this section, information is proprietary or competitive if revealing the information would cause the health
24 carrier's competitors to obtain valuable business information. A health carrier shall make the access plans,
25 absent proprietary information, available on its business premises and shall provide a copy of the plan upon
26 request.

27 (7) An access plan for each managed care plan offered in this state must describe or contain at
28 least the following:

29 (a) a listing of the names and specialties of the health carrier's participating providers;

30 (b) the health carrier's procedures for making referrals within and outside its network;

(c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in the managed care plan;

(d) the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(e) the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(f) the health carrier's method of informing covered persons of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(g) the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians and for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) the health carrier's process for enabling covered persons to change primary care professionals;

(i) the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and a participating provider or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and be transferred to other providers in a timely manner.

(j) any other information required by the department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

NEW SECTION. Section 14. Provider responsibility for care -- contracts -- prohibited collection practices. (1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, by which a participating provider will be notified on an ongoing basis of the covered health care services for which the participating provider is responsible, including any limitations or conditions on those health care services.

(2) A contract between a health carrier and a participating provider must set forth a hold harmless provision specifying protection for covered persons. This requirement is met by including in a contract a provision substantially the same as the following:

1 "The provider agrees that the provider may not for any reason, including but not limited to
2 *nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach*
3 of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or
4 have any recourse from or against a covered person or a person other than the health carrier or intermediary
5 acting on behalf of the covered person for services provided pursuant to this agreement. This agreement
6 does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically
7 provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis
8 to a covered person. This agreement does not prohibit a provider, except a health care professional who
9 is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to
10 that health carrier's covered persons and no others, and a covered person from agreeing to continue
11 services solely at the expense of the covered person if the provider has clearly informed the covered person
12 that the health carrier may not cover or continue to cover a specific service or services. Except as provided
13 in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available
14 for obtaining payment for services from the health carrier."

15 (3) A contract between a health carrier and a participating provider must state that if a health
16 carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered
17 persons will continue through the end of the period for which a premium has been paid to the health carrier
18 on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from
19 an inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an inpatient
20 facility on the date of insolvency or other cessation of operations must be continued by a provider until the
21 confinement in an inpatient facility is no longer medically necessary.

22 (4) The contract provisions that satisfy the requirements of subsections (2) and (3) must be
23 construed in favor of the covered person, survive the termination of the contract regardless of the reason
24 for termination, including the insolvency of the health carrier, and supersede an oral or written contrary
25 agreement between a participating provider and a covered person or the representative of a covered person
26 if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits
27 provisions required by subsections (2) and (3).

28 (5) A participating provider may not collect or attempt to collect from a covered person money
29 owed to the provider by the health carrier.

1 **NEW SECTION. Section 15. Selection of providers -- professional credentials standards.** (1) A

2 health carrier shall adopt standards for selecting participating providers who are primary care professionals
3 and for each health care professional specialty within the health carrier's network. The health carrier shall
4 use the standards to select health care professionals, the health carrier's intermediaries, and any provider
5 network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow
6 the health carrier to:

7 (a) avoid high-risk populations by excluding a provider because the provider is located in a
8 geographic area that contains populations or providers presenting a risk of higher than average claims,
9 losses, or use of health care services; or

10 (b) exclude a provider because the provider treats or specializes in treating populations presenting
11 a risk of higher than average claims, losses, or use of health care services.

12 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
13 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
14 through 21] and the rules implementing [sections 13 through 21].

15 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
16 with which the health carrier or its intermediary contract to employ specific providers or types of providers
17 who may meet their selection criteria or to contract with or retain more providers or types of providers than
18 are necessary to maintain an adequate network.

19 (4) A health carrier may use criteria established in accordance with the provisions of this section
20 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
21 carrier shall make its selection standards for participating providers available for review by the department
22 and by each health care professional who is subject to the selection standards.

23
24 **NEW SECTION. Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering

25 a managed care plan shall notify, in writing, prospective participating providers of the participating
26 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
27 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
28 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
29 requirements.

30 (2) A health carrier may not offer an inducement under a managed care plan to a participating

1 provider to provide less than medically necessary services to a covered person.

2 (3) A health carrier may not prohibit a participating provider from discussing a treatment option
3 with a covered person or from advocating on behalf of a covered person within the utilization review or
4 grievance processes established by the health carrier or a person contracting with the health carrier.

5 (4) A health carrier shall require a participating provider to make health records available to
6 appropriate state and federal authorities, in accordance with the applicable state and federal laws related
7 to the confidentiality of medical or health records, when the authorities are involved in assessing the quality
8 of care or investigating a grievance or complaint of a covered person.

9 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each
10 other before terminating the contract between them without cause. The health carrier shall make a good
11 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
12 notice of termination from or to a participating provider, to all covered persons who are patients seen on
13 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
14 termination is for cause or without cause. If a contract termination involves a primary care professional,
15 all covered persons who are patients of that primary care professional must be notified.

16 (6) A health carrier shall ensure that a participating provider furnishes covered benefits to all
17 covered persons without regard to the covered person's enrollment in the plan as a private purchaser or
18 as a participant in a publicly financed program of health care services. This requirement does not apply to
19 circumstances in which the participating provider should not render services because of the participating
20 provider's lack of training, experience, or skill or because of a restriction on the participating provider's
21 license.

22 (7) A health carrier shall notify the participating providers of their obligation, if any, to collect
23 applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of
24 coverage or of the participating providers' obligations, if any, to notify covered persons of the covered
25 persons' personal financial obligations for noncovered benefits.

26 (8) A health carrier may not penalize a participating provider because the participating provider,
27 in good faith, reports to state or federal authorities an act or practice by the health carrier that may
28 adversely affect patient health or welfare.

29 (9) A health carrier shall establish a mechanism by which a participating provider may determine
30 in a timely manner whether or not a person is covered by the health carrier.

1 (10) A health carrier shall establish procedures for resolution of administrative, payment, or other
2 disputes between the health carrier and participating providers.

3 (11) A contract between a health carrier and a participating provider may not contain definitions
4 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
5 [sections 8 through 29].

6 (12) A contract between a health carrier and a participating provider shall set forth all of the
7 responsibilities and obligations of the provider either in the contract or documents referenced in the
8 contract. A health carrier shall make its best effort to furnish copies of any reference documents, if
9 requested by a participating provider, prior to execution of the contract.

10
11 **NEW SECTION. Section 17. Emergency services.** (1) A health carrier offering a managed care plan
12 shall provide or pay for emergency services screening and emergency services and may not require prior
13 authorization for either of those services. If an emergency services screening determines that emergency
14 services or emergency services of a particular type are unnecessary for a covered person, emergency
15 services or emergency services of the type determined unnecessary by the screening need not be covered
16 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
17 determines that emergency services or emergency services of a particular type are necessary, those
18 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
19 carrier, acting through a participating provider or other authorized representative, has authorized the
20 provision of emergency services.

21 (2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork
22 provider within the service area of a managed care plan and may not require prior authorization of those
23 services if use of a participating provider would result in a delay that would worsen the medical condition
24 of the covered person or if a provision of federal, state, or local law requires the use of a specific provider.

25 (3) If a participating provider or other authorized representative of a health carrier authorizes
26 emergency services, the health carrier may not subsequently retract its authorization after the emergency
27 services have been provided or reduce payment for an item or health care services furnished in reliance on
28 approval unless the approval was based on a material misrepresentation about the covered person's medical
29 condition made by the provider of emergency services.

30 (4) Coverage of emergency services is subject to applicable coinsurance, copayments, and

1 deductibles.

2 (5) For postevaluation or poststabilization services required immediately after receipt of emergency
3 services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a
4 week, to facilitate review.

5
6 **NEW SECTION. Section 18. Use of intermediaries -- responsibilities of health carriers,**
7 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
8 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which
9 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

10 (2) A health carrier may determine whether a subcontracted provider participates in the provider's
11 own network or a contracted network for the purpose of providing covered benefits to the health carrier's
12 covered persons.

13 (3) A health carrier shall maintain copies of all intermediary health care subcontracts at the health
14 carrier's principal place of business in this state or ensure that the health carrier has access to all
15 intermediary subcontracts, including the right to make copies of the contracts, upon 20 days' prior written
16 notice from the health carrier.

17 (4) If required in a contract or otherwise by a health carrier, an intermediary shall transmit utilization
18 documentation and claims-paid documentation to the health carrier. The health carrier shall monitor the
19 timeliness and appropriateness of payments made to providers and health care services received by covered
20 persons. This duty may not be delegated to an intermediary by a health carrier.

21 (5) If required in a contract or otherwise by a health carrier, an intermediary shall maintain the
22 books, records, financial information, and documentation of services provided to covered persons at its
23 principal place of business in the state and preserve them for 5 years in a manner that facilitates regulatory
24 review.

25 (6) An intermediary shall allow the department access to the intermediary's books, records, claim
26 information, billing information, and other documentation of services provided to covered persons that are
27 required by any of those entities to determine compliance with [sections 13 through 21] and the rules
28 implementing [sections 13 through 21].

29 (7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to
30 the health carrier of the provisions of a participating provider's contract addressing the participating

1 provider's obligation to furnish covered benefits.

2
3 **NEW SECTION. Section 19. Contract filing requirements -- material changes -- state access to**
4 **contracts.** (1) On October 1, 1998, a health carrier offering a managed care plan shall file with the
5 department sample contract forms proposed for use with its participating providers and intermediaries.

6 (2) A health carrier shall file with the department a material change to a contract. The change must
7 be filed with the department at least 60 days before use of the proposed change. A change in a
8 participating provider payment rate, coinsurance, copayment, or deductible or other plan benefit is not
9 considered a material change for the purpose of this subsection.

10 (3) A health carrier shall maintain participating provider and intermediary contracts at its principal
11 place of business in this state, or the health carrier must have access to all contracts and provide copies
12 to the department upon 20 days' prior written notice from the department.

13
14 **NEW SECTION. Section 20. General contracting requirements.** (1) The execution of a contract
15 for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty
16 to provide health care services to a person with whom the health carrier has contracted and does not
17 relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules
18 implementing [sections 8 through 29].

19 (2) All contracts by a health carrier for the provision of health care services by a managed care plan
20 must be in writing and are subject to review by the department and the commissioner.

21
22 **NEW SECTION. Section 21. Contract compliance dates.** (1) A contract between a health carrier
23 and a participating provider or intermediary in effect on October 1, 1997, must comply with [sections 13
24 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department may
25 extend the April 1 date for an additional period of up to 6 months if the health carrier demonstrates good
26 cause for an extension.

27 (2) A contract between a health carrier and a participating provider or intermediary issued or put
28 into effect on or after April 1, 1998, must comply with [sections 13 through 21] and the rules implementing
29 [sections 13 through 21] on the day that it is issued or put into effect.

30 (3) A contract between a health carrier and a participating provider or intermediary not described

1 in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections
2 13 through 21] by April 1, 1999.

3
4 **NEW SECTION. Section 22. Department rules.** The department shall adopt rules to implement
5 [sections 13 through 21].

6
7 **NEW SECTION. Section 23. Quality assurance -- national accreditation.** (1) A health carrier
8 whose managed care plan has been accredited by a nationally recognized accrediting organization shall
9 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
10 organization to the department.

11 (2) If the department finds that the standards of a nationally recognized accrediting organization
12 meet or exceed state standards and that the health carrier has been accredited by the nationally recognized
13 accrediting organization, the department shall approve the quality assurance standards of the health carrier.

14 (3) The department shall maintain a list of accrediting organizations whose standards have been
15 determined by the department to meet or exceed state quality assurance standards.

16 (4) [Section 24] does not apply to a health carrier's managed care plan if the health carrier
17 maintains current accreditation by a nationally recognized accrediting organization whose standards meet
18 or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

19 (5) This section does not prevent the department from monitoring a health carrier's compliance
20 with [sections 23 through 27].

21
22 **NEW SECTION. Section 24. Standards for health carrier quality assessment programs.** A health
23 carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure
24 systems sufficient to accurately measure the quality of health care services provided to covered persons
25 on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this
26 requirement, a health carrier shall:

27 (1) establish and use a system designed to assess the quality of health care provided to covered
28 persons and appropriate to the types of plans offered by the health carrier. The system must include
29 systematic collection, analysis, and reporting of relevant data.

30 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory

1 agencies, providers, and consumers as provided in [section 26];

2 (3) report to the appropriate professional or occupational licensing board provided in Title 37 any
3 persistent pattern of problematic care provided by a participating provider that is sufficient to cause the
4 health carrier to terminate or suspend a contractual arrangement with the participating provider; and

5 (4) file a written description of the quality assessment program and any subsequent material
6 changes with the department in a format that must be prescribed by rules of the department. The
7 description must include a signed certification by a corporate officer of the health carrier that the health
8 carrier's quality assessment program meets the requirements of [sections 23 through 27].

9
10 **NEW SECTION. Section 25. Standards for health carrier quality improvement programs.** A health
11 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
12 adopt and use systems and methods necessary to improve the quality of health care provided in the health
13 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
14 by this section. To comply with this requirement, a health carrier subject to this section shall:

15 (1) establish an internal system capable of identifying opportunities to improve care;

16 (2) use the findings generated by the system required by subsection (1) to work on a continuing
17 basis with participating providers and other staff within the closed plan or closed component to improve
18 the health care delivered to covered persons;

19 (3) adopt and use a program for measuring, assessing and improving the outcomes of health care
20 as identified in the health carrier's quality improvement program plan. This quality improvement program
21 plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23
22 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program
23 plan within 30 days of implementation of the change. The quality improvement program plan must:

24 (a) implement improvement strategies in response to quality assessment findings that indicate
25 improvement is needed; and

26 (b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to
27 subsection (3)(a).

28
29 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
30 a closed plan or a combination plan shall document and communicate information, as required in this

section, about its quality assurance program. The health carrier shall:

(a) include a summary of its quality assurance program in marketing materials;

(b) include a description of its quality assurance program and a statement of patient rights and responsibilities with respect to that program in the certificate of coverage or handbook provided to newly enrolled covered persons; and

(c) make available annually to providers and covered persons a report containing findings from its quality assurance program and information about its progress in meeting internal goals and external standards, when available.

(2) A health carrier shall certify to the department annually that its quality assurance program and the materials provided to providers and consumers in accordance with subsection (1) meet the requirements of [sections 23 through 27].

(3) A health carrier shall make available, upon request and payment of a reasonable fee, the materials certified pursuant to subsection (2), except for the materials subject to the confidentiality requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier shall retain all certified materials for at least 3 years from the date that the material was certified or until the material has been examined as part of a market conduct examination, whichever is later.

NEW SECTION. Section 27. Confidentiality of health care and quality assurance records -- disclosure. (1) Except as provided in subsection (2), the following information held by a health carrier offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a person:

(a) information pertaining to the diagnosis, treatment, or health of a covered person, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form;

(b) information considered by a quality assurance program and the records of its actions, including testimony of a member of a quality committee, of an officer, director, or other member of a health carrier or its staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment, quality improvement, or quality assurance activities, or of any person assisting or furnishing information to the quality committee.

(2) The information specified in subsection (1) may be disclosed:

1 (a) as allowed by Title 33, chapter 19;

2 (b) as required in proceedings before the commissioner, a professional or occupational licensing
3 board provided in Title 37, or the department pursuant to Title 50, chapter 5, part 2;

4 (c) in an appeal, if an appeal is permitted, from a quality committee's findings or recommendations;

5 or

6 (d) as otherwise required by law or court order, including a judicial or administrative subpoena.

7 (3) Information specified in subsection (1) identifying:

8 (a) the provider may also be disclosed upon a written, dated, and signed approval of the provider
9 if the information does not identify the covered person;

10 (b) the covered person may also be disclosed upon a written, dated, and signed approval of the
11 covered person or of the parent or guardian of a covered person if the covered person is a minor and if the
12 information does not identify the provider;

13 (c) neither the provider nor the covered person may also be disclosed upon request for use for
14 statistical purposes only.

15
16 **NEW SECTION. Section 28. Enforcement.** (1) If the department determines that a health carrier
17 has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the
18 department may recommend corrective action to the health carrier.

19 (2) The commissioner may take an enforcement action provided in subsection (3) if:

20 (a) a health carrier fails to implement corrective action recommended by the department;

21 (b) corrective action taken by a health carrier does not result in bringing a health carrier into
22 compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a
23 reasonable period of time;

24 (c) the department demonstrates to the commissioner that a health carrier does not comply with
25 [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

26 (d) the commissioner determines that a health carrier has violated or is violating [sections 8 through
27 29] or the rules implementing [sections 8 through 29].

28 (3) The commissioner may take any of the following enforcement actions to require a health carrier
29 to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

30 (a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's

1 application for a certificate of authority; or

2 (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part
3 3.

4
5 **NEW SECTION. Section 29. Jurisdiction over contract actions.** The district courts have jurisdiction
6 over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

7
8 **NEW SECTION. Section 30. Codification instruction.** (1) [Section 7] is intended to be codified as
9 an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

10 (2) [Sections 8 through 29] are intended to be codified as an integral part of Title 33, and the
11 provisions of Title 33 apply to [sections 8 through 29].

12
13 **NEW SECTION. Section 31. Severability.** If a part of [this act] is invalid, all valid parts that are
14 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
15 applications, the part remains in effect in all valid applications that are severable from the invalid
16 applications.

17
18 **NEW SECTION. Section 32. Applicability.** [This act] applies to a health carrier as defined in
19 [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of
20 this section].

21
22 **NEW SECTION. Section 33. Effective dates.** (1) Except as provided in subsections (2) and (3),
23 [this act] is effective January 1, 1998.

24 (2) [Sections 22 and 30 through 32 and this section] are effective on passage and approval.

25 (3) [Sections 23 through 26] are effective October 1, 1999.

26 -END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0365, as introducedDESCRIPTION OF PROPOSED LEGISLATION:

An act providing for the regulation of health insurance carriers who offer managed care plans, providing for state network adequacy and quality assurance standards.

ASSUMPTIONS:Department of Public Health and Human Services (DPHHS):

1. DPHHS arranges for professional medical consultants to assist with the adoption of quality assurance standards.
2. This group of five consultants will meet six times in fiscal 1998 and four times in fiscal 1999.
3. Fees, per diem, and travel costs are estimated to be \$745 per meeting. MetNet costs are estimated at \$4,000 per year.
4. A Medical Director is contracted for 300 hours per year at \$100/hr for a total yearly contract cost of \$30,000.
5. Registered nurses (grade 16) will be needed during fiscal 1998 (1.00 FTE) and fiscal 1999 (1.00 additional FTE). The cost for a grade 16 FTE is \$34,640 including benefits. That brings personal services costs to \$34,640 in fiscal 1998 and \$69,280 in fiscal 1999.
6. Operating expense per FTE is estimated at \$2,500 per year plus travel of \$1,800 per year for a total per FTE per year of \$4,300.
7. Equipment costs for each FTE the first year include a PC and office equipment at a cost of \$4,000.
8. An estimated 120 hours of legal assistance in rule drafting will be required in the first year at a cost of \$53.00/hour for total legal costs of \$6,360.
9. Contract funds for a health systems analysis and program assistance will total \$32,000 per year.
10. It is estimated that 15% of the regulated HMOs will be Medicaid HMOs and that federal matching Medicaid funds will be available for this portion of the costs listed above. The federal match rate is 75% for medical personnel (Medical Director and RNs) and 50% for other administrative costs.

State Auditor:

11. The State Auditor's Office (SAO) will receive referrals from the DPHHS regarding complaints related to network adequacy and quality assurance. SAO will take appropriate enforcement actions with existing staff.
12. Growth in Health Management Organizations (HMOs) will generate an increase in the number of complaints to the Policyholder Services Bureau. HMOs restrict the number of options available to the HMO members. This will increase complaints requiring the SAO to add a 1.00 FTE compliance specialists, grade 14, to handle these complaints.

FISCAL IMPACT:Department of Public Health and Human ServicesExpenditures:

	<u>FY98</u>	<u>FY99</u>
FTE	1.00	2.00
Personal Services	\$ 34,640	\$ 68,280
Operating Expenses	81,130	77,580
Equipment	4,000	4,000
Total	\$122,470	\$156,260

Funding:

General Fund (01)	\$110,760	\$140,615
Federal Medicaid Funds (03)	11,710	15,645
Total	\$122,470	\$156,260

(Continued)

Dave Lewis 2-19-97
 DAVE LEWIS, BUDGET DIRECTOR DATE
 Office of Budget and Program Planning

Steve Benedict 2/20/97
 STEVE BENEDICT, PRIMARY SPONSOR DATE

Fiscal Note for SB0365, as introduced**SB 365**

(continued)

State AuditorExpenditures:

	<u>FY98</u>
	<u>Difference</u>
FTE	0.00

	<u>FY99</u>
	<u>Difference</u>
	1.00
	\$ 31,835
	4,000
	<u>3,585</u>
	\$ 39,420

Personal Services
Operating Expenses
Equipment
Total

<u>0</u>
\$ 0

Funding:

General Fund (01)

0

\$ 39,420

Net Impact on Fund Balance: (Revenue minus Expenses)

General Fund (01)

(\$110,760)

(\$180,035)

SENATE PUBLIC HEALTH, W & S

Page 6

- BILL NO - REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE - REREFERRED - DATE READ

SB0317	ECK, DOROTHY	2/08	2/14	2/14	CHANGE MEDICAID ELIGIBILITY AND ALLOW DPHHS TO CHARGE SLIDING SCALE OF FEES	PASS AS AMENDED	2/19	VOTE:	2/20
SB0324	ESTRADA, SHARON	2/10	2/14		PROVISIONS REGARDING COVERAGE OF POSTMASTECTOMY CARE/BREAST CANCER TREATMENT	PASS AS AMENDED	2/14	VOTE: UNANIMOUS	2/18
SB0331	THOMAS, FRED	2/11	2/17		REVISING WORKERS' COMPENSATION REIMBURSEMENT FOR HOSPITALS	PASS AS AMENDED	2/19	VOTE:	2/20
SB0338	GROSFIELD, LORENTS	2/12	2/17		REQUIRE LICENSURE OF CERTAIN OUTFITTING & GUIDE FACILITIES & GUEST RANCHES	PASS AS AMENDED	2/21	VOTE:	2/22
SB0365	BENEDICT, STEVE	2/14	2/19		REQUIRE HMO NETWORK ADEQUACY AND QUALITY ASSURANCE	PASS AS AMENDED	2/21	VOTE:	2/22
SJ0008	ESTRADA, SHARON	2/08	2/14		RESOLUTION TO CONGRESS FOR MEDICARE MAMMOGRAM COVERAGE	DO PASS	2/14	VOTE: UNANIMOUS	2/18
SJ0016	SHEA, DEBBIE	3/08	3/14		REQUIRE DPHHS TO CONDUCT STUDY OF PROGRAM RELATED TO HOME COMPANIONS	DO PASS	3/17	VOTE:	3/19

MINUTES

MONTANA SENATE 55th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE, & SAFETY

Call to Order: By **ACTING CHAIRMAN LARRY BAER**, on February 19, 1997, at 3:15 PM, in Room 410.

ROLL CALL

Members Present:

Sen. Steve Benedict, Chairman (R)
Sen. James H. "Jim" Burnett, Vice Chairman (R)
Sen. Larry L. Baer (R)
Sen. Chris Christiaens (D)
Sen. Bob DePratu (R)
Sen. Dorothy Eck (D)
Sen. Sharon Estrada (R)
Sen. Eve Franklin (D)
Sen. Fred Thomas (R)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Services Division
Karolyn Simpson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: SB 365, 2/17/97
Executive Action: SB 331, SB 317, SB 156, SB
162, SB 128, SB 23

{Tape: 1; Side: A; Approx. Time Count: 3:15 PM}

HEARING ON SB 365

Sponsor: SENATOR STEVE BENEDICT, SD 30, Hamilton

Proponents: Jerry Loendorf, MT Medical Assn.

Mark O'Keefe, State Auditor
Kathy Caniparoli, Nurse Practitioner
Tanya Ask, Blue Cross and Blue Shield of MT
Tom Ebzery, Yellowstone Community Health Plan
Tom Hopgood, Health Insurance of America
Jerry Driscoll, MT Life Underwriters
Gloria Hermanson, MT Psychological Assn.
Laurie Ekanger, Department of Health

Kip Smith, Primary Care Assn.
John Flink, MT Hospital Assn.
Bob Torres, MT Chapter Social Workers
Andrea Merrill, MT Mental Health Assn.
Anita Bennett, MT Logging Assn.
Dick Pattison, MT Senior Citizens
Al Smith, MT Advocacy Program

Opponents: Ed Groggans, MT Benefit Plan

Opening Statement by Sponsor:

SENATOR STEVE BENEDICT, SD 30, Hamilton, said SB 365 minimizes regulatory oversight, while assuring quality of care, and access to health care for all Montanans. It will help facilitate the growing managed care market in Montana without placing undue government regulations and red tape on the managed care organizations that now operate in Montana, or wish to enter this market in the future. He wants to make sure the goals of cost cutting don't deny consumers access to quality health care and believes in the free market and wants to maintain high standards for quality care. Senate Bill 365 creates quality and adequacy network standards. Managed care is growing in the nation and Montanans must be protected by legislation that addresses access, affordability, and quality of care.

Proponents' Testimony:

Jerry Loendorf, representing Montana Medical Association, said there are good things to say about this bill because it strikes a balance between providing good care at a low cost and it contains a lots of consumer protections. We need to let managed care be able to flourish, yet grow and need to provide an adequate number and types of providers to ensure covered persons receive the care they contract to receive. Health carriers are required to provide an access plan to the Department, which must show they meet the general requirements. The bill requires high risk persons not be excluded, whose claims may be higher than the average.

Mark O'Keefe, State Auditor, said he supports SB 365 because it is a good bill but has one major flaw and some weaknesses. He said the bill is a result of **SENATOR BENEDICT's** realizing people rejected the Clinton health care plan because they did not want government involved in health care, but now insurance companies are doing what the government did: setting up managed care entities that tell consumers what type of care they can get and from whom they can get it. The goal of the bill is to design a system using available resources with Montanans making the rules, not the government. The goal is guaranteed quality of health care and ensuring managed care entities are financially solvent. It will protect consumers because they need to feel they are treated well and have access to quality health care. This bill creates efficiency by coordination between the Insurance Commissioners Office and the Department of Health, under the direction of the Governor. Senate Bill 365 creates a double regulation of the managed care industry because it removes board of network

adequacy, which was contained in SB 128. That is a key consumer protection provision that should be put back in this bill. It also removed the committee that approved the standards, which leaves the bureaucrats and politicians to set the quality standards for managed care. The Insurance Department would continue to regulate financial solvency, but under the bill there is no institutional coordination with the Health Department which is double regulation of the health industry. Without the board, there will be a doubling of work and cost and this will be passed on to the taxpayers, insurers and consumers. With the removal of the Medical Advisory Council, consumers and providers will not have a voice in quality assurance and managed care. Providers should be included in the quality improvement plan and consumers should be allowed to comment on quality and quality improvement of their health plan, because they are receiving the health care. There are three things that should be considered. Whether or not a board is critical to force the agencies to cooperate with one another, inclusion of a medical advisory council, and the quality improvement provisions of this bill.

Kathy Caniparoli, Nurse Practitioner, representing Montana Nurses Association, said they offer qualified support for SB 365. They believe managed care plans must be accountable to the people of Montana for the quality of services offered. They are offering an amendment to section 15-1. (EXHIBIT 1)

Tanya Ask, Blue Cross and Blue Shield of Montana, said they support SB 365 and have proposed a conceptual amendment to offer a board the inclusion of a board of network adequacy and quality assurance, representing the Governor through the Department of Health, and the Insurance Department, with a delayed effective date of July 1, 2001. The two managed care organizations in Montana are HMO Montana and Yellowstone Community Health Plan are community-based provider-driven organizations. Because they have been responsive, they have not generated the types of complaints that have occurred in other parts of the country. The Blue Cross and Blue Shield focus for the future is an even greater commitment to primary care, to a physician-directed network base, and community-based organization.

Tom Ebzery, representing Yellowstone Community Health Plan, testified in support of SB 365 and said they are one of two licensed and operational HMOs in Montana. He offered amendments to SB 365 and said they would not agree to an amendment to put the board back in. If it was a bad idea, it will still be a bad idea in 2001. (EXHIBIT 2)

Tom Hopgood, representing Health Insurance Association of America, said they are interested in health maintenance organizations and in managed care. They are not wide-spread in Montana but they are coming. It's in the best interest of providers of medical service, insurers, and the citizens of Montana to see that medical services are delivered in a timely and cost-effective manner and continued quality of service. This

bill does that and the interests of consumers are protected in this bill.

Jerry Driscoll, Montana Association Life Underwriters, said SB 365 provides for quality of care for participants and provides a level playing field for the agents and insurance companies.

Gloria Hermanson, representing Montana Psychological Association, said SB 365 allows for no provider or consumer input with regard to adequacy or quality of care. They support the bill only if it is amended to include a board of network adequacy and quality assurance, and a quality-review council. They are offering amendments to include the board and council. (EXHIBITS 3 & 4)

Laurie Ekanger, Department of Public Health and Human Services, said they support SB 365. They have worked with the Insurance Commissioner, his staff, and **SENATOR BENEDICT** on language of this bill. It's an important priority to the Governor that we have quality assurance standards and consumer protection for the people of Montana.

Kip Smith, Associate Director, Montana Primary Care Association, said they support this bill but have two concerns and are offering amendments. (EXHIBIT 5) They have struggled with the definition of health maintenance organizations in existing law. That definition of an HMO is in section 3, #7 of the bill. The part they have struggled with is where it defines pre-paid or other financial basis. The change in that definition does not effectively clarify who is going to be affected by this bill. He thought pre-paid capitated is what was wanted but that is not what is in Montana. The Insurance Commissioner's Office interpretation of the existing is that it applies to any insurance plan that has a closed provider network. The language offered in their amendment for health maintenance organization more adequately addresses who is covered by this law. Their other concern is the lack of any periodic reporting regarding network adequacy and quality improvement plan.

John Flink, Montana Hospital Association, said they share the concerns raised about managed care and want to avoid the horror stories that have occurred elsewhere. Senate Bill 365 will enable us to achieve that goal, while striking a balance on the regulatory side. They raised concerns about the impact SB 128 would have on HMO administrative costs, but these issues have been addressed in SB 365. They do not support adding the board. The definition of health carrier because it is vague and may be a problem as to how physician hospital organizations are treated, and has an amendment to deal with this issue. (EXHIBIT 6)

Bob Torres, representing Montana Chapter Social Workers, said they support SB 365 with the provision that the amendments offered by the Montana Psychological Association are included. If it is a bad idea to have a board of network adequacy, it should be found out sooner rather than later.

Andrea Merrill, Executive Director, Montana Mental Health Association, said they support the extra checks and balances contained in the amendments returning the board of network adequacy and quality assurance and the review board.

Anita Bennett, Member Services Director, Montana Logging Association, read a statement of support from the **Montana Association of Health Care Purchasers. (EXHIBIT 7)**

Dick Pattison, President, Montana Senior Citizens Association, said they support SB 365 but are concerned about the lack of a board because consumers need representation and want the board restored to the bill.

{Tape: 1; Side: B; Approx. Time Count: 4:00 PM}

Al Smith, Executive Director, Montana Advocacy Program, said they like the basics of the bill because people with disabilities facing managed care need some protection. They agree with the concerns expressed by **Mark O'Keefe** and the **Montana Psychological Association** and agree with their amendments. The anti-gag order section of the bill lacks effectiveness and really has no enforcement power. They think consumer input is necessary for quality and adequacy of care and would like to have a quality review council included.

Opponents' Testimony:

Ed Groggans, Montana Medical Benefit Plan, said he opposes the bill for two reasons. This is another mandate that will cost consumers more money. There are no horror stories coming from the two operating managed care organizations in Montana, but when too restrictive legislation is passed, only these two will be operating in Montana and possibly keeping others from coming into Montana to do business.

Questions From Committee Members and Responses:

SENATOR FRED THOMAS asked **Tom Ebzery** to address the appeals process and the question about the boards.

Tom Ebzery said the nurses amendment gets into the credentialing statute, and when an HMO is going through the credentialing process, if someone is excluded there must be clear evidence of limited cost effectiveness or quality of care which lacks scientific support. This is similar to some of the language in SB 190. Any class of providers could be added in to the credentialing process, and they have a problem with this. He hasn't seen the appeal process amendment. The board in **SENATOR HARGROVE's** bill was composed of Department of Health Director, Insurance Commissioner and a medical director, and didn't think it was necessary.

SENATOR EVE FRANKLIN asked **SENATOR BENEDICT** to address the unification of the Department of Health and State Auditors office.

SENATOR BENEDICT said the biggest problem with SB 128 was it created additional bureaucracy that was not necessary. There is no need for a paid medical director because the Department of Health has the capability to either contract out or go in-house for some of those functions. Coordination between the auditors office and Department of Health is excellent now, but doesn't know how it would be in future administrations. He would agree to put something into statute for later on, but thinks the council is not necessary.

SENATOR FRANKLIN said in regard to the communications between the Department of Health and Insurance Commissioner, asked **SENATOR BENEDICT** if he would support any of the amendments for the board.

SENATOR BENEDICT said he would agree to putting a delayed effective date for the board, allowing the board to come into existence when we find out who is going to be in the next administration and Insurance Commissioner. He can't support the council amendment. He is opposed to putting quality improvement standards in statute that can't be met by some of the smaller and start-up HMOs, and it's adequate for the Department of Health, under rule-making, to decide what those quality improvement standards should be.

SENATOR CHRIS CHRISTIAENS asked **SENATOR BENEDICT** what he would consider to be a material change in reporting.

SENATOR BENEDICT said **Al Smith** had mentioned the only thing in plan that needed to be provided to the Department (see page 14, section 7, a through j) was the list of providers that needed to be updated, and why not just submit that every year. **SENATOR BENEDICT** said that is unnecessary, burdensome paperwork and regulation. If the plan changes, notify the department, but if not, why submit a yearly plan. Once the plan is filed, that same plan shouldn't have to be submitted every year.

SENATOR CHRISTIAENS asked what would constitute a need to update that plan.

SENATOR BENEDICT said that is getting into semantics, but sees a material change as not doing one of the things in section 7, a through j.

Susan Fox said she would like to see if there is a legal definition or how it is used in the insurance world.

SENATOR CHRISTIAENS said this bill, like SB 128, does not address durable medical supplies and equipment, and asked what would be included for the person with disabilities.

SENATOR BENEDICT said he would take a look at that issue.

SENATOR ECK asked about the use of the terms quality assessment, quality assurance and quality improvement and the whole section of quality assurance.

SENATOR BENEDICT said that is something the Department of Health would decide, under Department rules. They have the in-house capabilities to determine the standards for network adequacy and quality improvement and quality assurance, and may allow to use their own professional expertise and also to contract out.

SENATOR ECK expressed her concern that certain people would be excluded (network adequacy standard, p 13) and it seems that would cover the services of others such as nurse practitioners, chiropractors, etc. and asked if it does cover them.

SENATOR BENEDICT said it does cover them.

SENATOR ECK said the definitions are confusing because there are several sections.

SENATOR BENEDICT said new definitions are needed under the managed care part of it.

SENATOR EVE FRANKLIN asked about taking out the consumer advisory council and what the process would be if a consumer has a problem.

SENATOR BENEDICT said under DPHHS and their use of the Montana Administrative Procedures Act, there is an adequate forum for consumers to express concerns about network adequacy or quality assurance.

SENATOR FRANKLIN asked if the Department of Health would deal with consumer concerns.

Laurie Ekanger said the Council of Provider Specialties in SB 128 included a health carrier member and one consumer member. The responsibility of that group was to provide medical expertise to help the Department design proposed quality standards. They plan to do this without a prescribed council but would bring in specialties to help.

SENATOR BENEDICT said consumer complaints would be handled by the Insurance Commissioner.

SENATOR FRANKLIN asked how consumer complaints would be handled.

Mark O'Keefe said all of the regulatory muscle is in the Commissioners office and that is the reason for his concern about the board. Because they are a criminal justice agency, they must do things differently than the Department of Health. If the Insurance Commissioner gets a consumer complaint, if there are criminal activities going on, they can deal with it.

Closing by Sponsor:

SENATOR STEVE BENEDICT thanked the committee for its patience and all of those who testified for their input. This bill will be something the legislature can be proud of and the people of Montana can be proud of.

Break: 4:24-4:37 PM

CHAIRMAN BENEDICT resumed the chair.

EXECUTIVE ACTION ON SB 331

Motion: SENATOR FRED THOMAS moved SB 331 DO PASS.

Motion: SENATOR THOMAS moved the AMENDMENTS (SB033101.agp) to SB 331 DO PASS.

Discussion: SENATOR THOMAS said this bill was opposed by George Wood concerning the amendments. These amendments clarify the intent of the bill to be understandable by all.

SENATOR SHARON ESTRADA asked SENATOR THOMAS if Don Allen and George Wood were opponents to SB 331.

SENATOR THOMAS said a lot of Don Allen's concerns were explained away after the hearing, and with these amendments, George Wood has no difficulty with the bill.

CHAIRMAN BENEDICT said George Wood also expressed that to him.

Vote: The DO PASS motion for the AMENDMENTS to SB 331 CARRIED UNANIMOUSLY.

Motion/Vote: SENATOR THOMAS moved SB 331 DO PASS AS AMENDED. The motion CARRIED UNANIMOUSLY.

EXECUTIVE ACTION ON SB 128

Motion: SENATOR EVE FRANKLIN moved SB 128 DO PASS.

Discussion: SENATOR FRANKLIN said she believes strongly in the concept of network adequacy to have those two boards in place and have the consumer and provider on the council. This is a stronger bill in terms of consumer protection and institutionalizing communications between the Governor's office and the Department of Health, and thinks SB 128 is better than SB 365.

Motion/Vote: SENATOR LARRY BAER moved to TABLE SB 128. The motion CARRIED with SENATORS FRANKLIN and CHRISTIAENS voting NO.

EXECUTIVE ACTION ON SB 317

My name is Cathy Caniparoli. I am a nurse practitioner from Great Falls and am representing the Montana Nurses Association.

We are offering qualified support for SB365 sponsored by Senator Benedict. We believe that managed care plans must be accountable to the people of Montana for the quality of the services offered and the fiscal stability of the managed care plan. We continue to have reservations about the lack of protection for the individual members of the managed care plan.

We would also offer an amendment to Section 15 (1) by adding a (c). The copy of the proposed text is on the next page. This would set up an appeal process when a managed care plan excludes a class of provider from the provider panels. This amendment would remove the need for the Legislature to address these issues every session; it would ensure that people in small, rural communities would have access to qualified providers even if they could not support a more expensive type of provider and would ensure that exclusionary decisions by managed care plans were based on issues of quality and cost-effectiveness.

We urge a DO PASS WITH AMENDMENTS of this bill.

AMENDMENT TO SB 365

New section. Section 15. Selection of providers-professional credentials standards.

Add (c) Exclude a class of providers who are acting within the scope of practice defined by the state of Montana without clear evidence of limited cost-effectiveness and/or quality of care which lacks scientific support.

Rationale: Section 15 allows the health carrier to develop professional credentials standards for managed care plans which are offered in the state. It is inevitable that there will be classification of health care providers who are excluded from the managed care plans. The insurance industry has a long history of excluding various classifications of providers. In the past, these issues have come before the Legislature. The Legislature is not the best forum for the mediation of these issues because of the biannual sessions, and because the issues are complex and require in-depth knowledge of insurance issues and the various scope of practice. It would be more cost-effective to have a process which is mediated by the department and enforced by the Office of Insurance Commissioner. This would allow for efficient, cost-effective oversight of this issue.

Testimony of Tom Ebzery in Support of SB 358

Mr. Vice Chairman and members of the committee. My name is Tom Ebzery, a Billings attorney, and I appear here today on behalf of the Yellowstone Community Health Plan. YCHP is one of three licensed health maintenance organizations in Montana and one of only two currently operating. SB 358 as well as SB 128 by Sen. Hargrove provide state network adequacy and quality assurance standards which will apply to only two entities if this legislation passes. I believe the committee should know this legislation, when enacted, will provide standards for two HMOs. We believe SB 358 is an improvement upon SB 128 and recognizes that some of the legislation is simply not needed and this bill should be adopted.

It is no secret that we have questioned the wisdom of imposing an additional layer of standards upon a state with two health maintenance organizations. The Legislature appears to have spoken and we believe SB 358 represents the best alternative for both the regulator and the regulated.

Others will discuss specific sections of the bill and I will discuss a few areas of concern and will offer three small amendments which I will discuss in a moment.

I do have one question--why are definitions of "provider" different for PPOs and HMOs. (See page 3, line 15 and page 5, line 23). Also "Health Benefit Plan" (page 2, line 26 and page 11, line 21); "Health Care Provider" (page 11, line 27) and "Health Care Services" (page 3, lines 6-8 and page 11, line 28). It may be too late to look at this in the Senate, but there may be a desire to clean these up or make them consistent in the House.

Let me explain my amendments.

Amendment #1: On page 14, lines 12 and 13, we are recommending that subsection (4) be deleted because it imposes a burden upon the HMO to find out knowledge it simply cannot obtain. We would practically have to require each physician to produce his or her tax returns. It represents some canned national language without regard to whether it could work. We have deleted this language.

Amendment #2: On page 15, line 22, we are adding a new subsection to the access plan section. This section tells the HMO what he needs to submit but leaves it totally open as to how long the departments can take in reviewing the access plan.

Amendment #3: Page 15, lines 24 and 25. We do not believe this should be spelled out in a contract that is extraneous.

We believe with these amendments, the legislation is ready to move forward and even though there are concerns at YCHP about meeting these timeframes and the additional costs of compliance, we support the bill.

Amendments to SB 365
prepared by
Yellowstone Community Health Plan

1. Page 14, lines 12 -13
delete (4) and renumber subsequent sections.
2. Page 15, line 22
insert: (8) The department shall assure timely and expedited review and approval of the access plan and other requirements in this section.
3. Page 15, line 24 - 25
delete "described in detail in the contract,"

PROPOSED AMENDMENTS
Senate Bill 365

1. Page 18, line 9
Following: "A"
Strike: "health carrier and"
2. Page 18, lines 9 & 10,
Following: "notice to"
Strike: "each other"
Insert: "the health carrier"
3. Page 18, line 10,
Following: "contract"
Strike: "between them"
Insert: "with it"
4. Page 18, line 10,
Following: "cause"
Insert: "A participating provider shall not be
terminated without cause. Any decision of a
health carrier to terminate a participating
provider shall be subject to appeal of such
decision by the participating provider to the
quality review council. The quality review
council shall hear the appeal after giving
reasonable notice thereof to each party. The
decision to terminate shall not be final
unless it is approved by the quality review
council."

Proposed Amendments
S.B. 365
Introduced Bill Copy
February 19, 1997

1. Title, line 5.
Following: "PLANS;"
Insert: "CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE; CREATING A NETWORK AND QUALITY REVIEW COUNCIL; PROVIDING FOR THE POWERS AND DUTIES OF THE BOARD AND COUNCIL;"
2. Statement of intent, page 1, line 16.
Strike: "12, 13"
Insert: "14, 17"
Strike: "22"
Insert: "25"
3. Statement of intent, page 1, line 17.
Following: "services"
Insert: "and because [section 14] requires the board of network adequacy and quality assurance to adopt rules."
4. Statement of intent, page 1, line 18.
Strike: "department"
Insert: "board of network adequacy and quality assurance"
5. Statement of intent, page 1, line 19.
Statement of intent, page 1, line 20.
Statement of intent, page 1, line 22.
Page 6, line 18.
Page 10, lines 5, 8, 24, 25, and 28.
Page 13, lines 1 and 2.
Page 19, line 5.
Page 20, line 8.
Page 21, lines 17 and 18.
Page 25, lines 17, 22, 25, 27, and 29.
Page 26, lines 6 and 10.
Strike: "8"
Insert: "10"
Strike: "29"
Insert: "32"
6. Statement of intent, page 1, line 29.
Strike: "department"
Insert: "board of network adequacy and quality assurance"

7. Statement of intent, page 1, line 30.

Strike: "department's"

Insert: "board's"

Strike: "department"

Insert: "board"

Following: "shall"

Insert: "adopt processes under which the board and the network and quality review council undertakes regulation of managed care plans, specify the considerations affecting board and council decisions relating to managed care plans, and"

8. Statement of intent, page 2.

Following: line 1

Insert: "Rules providing state network adequacy and quality assurance standards, other than provider credential verification requirements, may be adopted only by the board of network adequacy and quality assurance."

9. Statement of intent, page 2, line 2.

Strike: "19"

Insert: "22"

10. Page 2.

Following: line 8.

Insert: "NEW SECTION. **Section 1. Board of network adequacy and quality assurance.** (1) There is a board of network adequacy and quality assurance. The board is composed of a medical director, the director of the department of public health and human services provided for in 2-15-2201, and the commissioner of insurance provided for in 2-15-1903.

(2) The medical director is appointed by the governor and must be licensed as a physician by the state of Montana. The medical director must be appointed from the list of physician specialties provided in [section 2(2)]. The governor may remove a medical director at any time and appoint a new medical director to the position.

(3) The medical director is entitled to compensation in an amount determined by the governor, under guidelines adopted by the governor.

(4) The general powers and duties of the board are provided in [section 14].

(5) The provisions of 2-15-122(5) through (8) apply to the board and its members. However, the governor shall determine the

compensation of the medical director as provided in subsection (3).

(6) The board is attached for administrative purposes to the department of public health and human services pursuant to 2-15-121.

NEW SECTION. **Section 2. Network and quality review council.** (1) There is a network and quality review council. The council consists of seven health care providers, one health insurance carrier quality assurance specialist and one health care consumer representative who is not affiliated with the health care or insurance industry. The medical director provided for in [section 1] presides over meetings of the council.

(2) The medical director occupies one of the seven health care provider positions on the council. The board of network adequacy and quality assurance provided for in [section 1] shall appoint the remaining six health care providers to the council and shall ensure that one family practice physician, one pediatric physician, one internal medicine physician, and one obstetrician/gynecologist serve as members of the council. The board shall also appoint a mental health professional and one of the following:

(a) a physician assistant-certified licensed pursuant to Title 37, chapter 20;

(b) an advanced-practice registered nurse licensed pursuant to Title 37, chapter 8, part 4; or

(c) a registered nurse licensed pursuant to Title 37, chapter 8, who is nationally certified in quality assurance or who has current experience in the field of quality assurance and network adequacy.

(3) The commissioner of insurance provided for in 2-15-1903 shall appoint a health insurance carrier quality assurance specialist to the council.

(4) The director of the department of public health and human services, provided for in 2-15-2201, shall appoint the health care consumer representative to the council.

(5) (a) The initial council members' terms, not including the medical director, are as follows and must be assigned by lot:

(I) two of the members serve a term of 1 year;

(ii) two of the members serve a term of 2 years; and

(iii) three of the members serve a term of 3 years.

(b) Subsequent council members serve for a term of 3 years.

(c) A member of the council may be replaced for cause by

the appointing authority. A vacancy on the council is filled by the appointing authority. A council member's term continues until that member's successor is appointed. A member of the council may be reappointed.

(6) The general powers and duties of the council are provided for in [section 15].

(7) The provisions of 2-15-122(5) through (8) apply to the council and its members. However, the medical director serves as presiding officer of the council.

(8) The council is attached for administrative purposes to the department of public health and human services pursuant to 2-15-121."

Renumber: subsequent sections

11. Page 10, line 14.

Strike: "implementation of"

Insert: "powers and duties of the board and council in order to adopt and implement"

12. Page 10, line 23.

Following: "compliance"

Insert: "through the coordinated efforts of the commissioner, the department, the board, and the council"

13. Page 10.

Following: line 29.

Insert: "(1) "Board" means the board of network adequacy and quality assurance provided for in [section 1]."

Renumber: subsequent subsections

14. Page 11.

Following: line 2

Insert: "(4) "Council" means the network and quality review council provided for in [section 2]."

Renumber: subsequent subsections

15. Page 13, line 7.

Strike: "Department"

Insert: "Board"

16. Page 13, line 8.

Strike: "department"

Insert: "board"

17. Page 13, line 13.

Strike: "department"

Insert: "board"

18. Page 13, line 14.

Strike: "department"

Insert: "board"

19. Page 13, lines 17 and 18.

Strike: subsection (3) in its entirety

20. Page 13.

Following: line 18.

Insert: "NEW SECTION. Section 15. Council -- general powers and duties. (1) The council shall:

(a) make recommendations to the board for state network adequacy and quality assurance standards;

(b) annually review the state network adequacy and quality assurance standards provided in [sections 16 through 24] and the rules implementing [sections 16 through 24] and recommend amendments to those standards to the board;

(c) annually review a health carrier's quality assessment program in accordance with standards established in [sections 26 through 30] and the rules implementing [sections 26 through 30];

(d) annually review a health carrier's quality improvement plan or program in accordance with standards established in [sections 26 through 30] and the rules implementing [sections 26 through 30]; and

(e) annually review managed care plan networks for compliance with standards for network adequacy provided in [sections 16 through 24] and the rules implementing [sections 16 through 24].

(2) The council may:

(a) recommend changes to a health carrier in the health carrier's quality assessment program, quality improvement plan or program, quality assurance program, or network adequacy;

(b) recommend to the board corrective action necessary for the health carrier to achieve compliance with state network adequacy and quality assurance standards;

(c) make recommendations to individual health care providers or to appropriate professional and occupational licensing boards provided in Title 37 concerning compliance with state network adequacy and quality assurance standards; and

(d) request and obtain the assistance of other health care providers in developing quality assurance standards and determining corrective action."

Renumber: subsequent sections.

21. Page 15, lines 20 and 21.
Page 17, lines 13, 14, and 15.
Page 20, lines 27 and 28.
Page 21, lines 23, 24, 28, and 29.
Page 22, lines 1 and 5.
Replace: "13"
Insert: "16"
Strike: "21"
Insert: "24"

22. Page 20, line 25.
Following: "allow the"
Insert: "commissioner,"
Following: "department"
Insert: ", board, and council"

23. Page 22, line 16.
Strike: "24"
Insert: "27"

24. Page 22, line 18.
Strike: "23"
Insert: "26"
Strike: "27"
Insert: "30"

25. Page 22, line 20.
Strike: "23"
Insert: "26"
Strike: "27"
Insert: "30"

26. Page 23, line 1.
Strike: "26"
Insert: "29"

27. Page 23, line 8.
Strike: "23"

Insert: "26"
Strike: "27"
Insert: "30"

28. Page 23, line 11.
Strike: "24"
Insert: "27"

29. Page 23, line 21.
Strike: "23"
Insert: "26"

30. Page 23, line 22.
Strike: "27"
Insert: "30"

31. Page 24, line 11.
Strike: "23"
Insert: "26"
Strike: "27"
Insert: "30"

32. Page 24, line 14.
Strike: "27"
Insert: "30"

33. Page 25, line 16.
Following: "department"
Insert: "or the council"

34. Page 25, line 18.
Strike: "department"
Insert: "council"

35. Page 25, line 20.
Strike: "department"
Insert: "council"

36. Page 25, line 24.
Strike: "department"
Insert: "council"

37. Page 26, line 8.

Strike: "7"

Insert: "9"

38. Page 26, line 19.

Strike: first and second "10"

Insert: "12"

39. Page 26, line 24.

Strike: "22"

Insert: "25"

Strike: "30"

Insert: "33"

Strike: 32"

Insert: "35"

40. Page 26, line 25.

Strike: "23"

Insert: "26"

Strike: "26"

Insert: "29"

Montana Primary Care Association, Inc.

ALAN W. STRANGE, Ph.D.
Executive Director

KIP SMITH
Associate Director

PROPOSED AMENDMENTS TO SENATE BILL 365
PRESENTED TO SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
February 19, 1997

Section 3. Section 33-31-102, MCA; Definitions

(7) "Health maintenance organization" means a person who provides or arranges for the provision of basic health care services to enrollees through a provider network utilizing either a closed plan or combination plan, as defined in [section 10], and is compensated for the services at a predetermined rate paid by either an enrollee or health plan sponsor.

If this amendment is accepted, at least two additional definitions would need to be added to Section 3:

"Network" means the group of participating providers that provides health care services to a managed care plan.

(This is the same definition currently included in Section 10)

"Health plan sponsor" means a person who contracts with a health maintenance organization for basic health care services on behalf of an enrollee."

Section 13. Network adequacy -- standards -- access plan required.

Amend the last sentence of (5) following "change" to read:

"and a copy of its most recent access plan on October 1 of each year."

Section 25. Standards for health carrier quality improvement programs.

Amend the third sentence following "change" to read:

"and a copy of its most recent quality improvement program plan on October 1 of each year."

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 2/19/97
BILL NO. SB365

Amendment to SB 365
Prepared by
The Montana Hospital Association

1. Page 12, line 3
Insert: after "plan." "This is not meant to apply to a physician-hospital organization or other provider-sponsored organization."

EXHIBIT NO. 7DATE 2/19/97

Montana Association of Health Care Purchasers

The Montana Association of Health Care Purchasers supported SB 128 and also supports SB 365 requiring the establishment of minimum standards for Health Maintenance Organizations operating in Montana.

The Montana Association of Health Care Purchasers is negotiating with physicians and hospitals across the state interested in offering community based managed care options. MAHCP supports the development of managed care in Montana that is dedicated to improving quality and controlling costs. SB128 and SB365 establish minimum quality standards that will allow Montanans to compare the quality of care provided by these plans. This legislation insures that quality will be measured and reported as managed care options develop in Montana.

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DATE 2/19/97
 SENATE COMMITTEE ON Public Health
 BILLS BEING HEARD TODAY: SB 365

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Check One

Name	Representing	Bill No.	Support	Oppose
<i>Mark O'Keefe</i>	State Auditor	365		
<i>Cathy Campanelli</i>	MT New Associate	365		
<i>Tip Smith</i>	MPCA	365	✓	
<i>Laurie Etanger</i>	DPHHS	365	✓	
<i>TANYA ABK</i>	SUBMIT	365	✓	
<i>Al Smith</i>	MIAP	365		✓
<i>Jim T. Roensch</i>	MT. Publ. Assoc	365	✓	
<i>Jimmy Cassill</i>	mt Assoc Life Underwriters	365	✓	
<i>Gloria Klemmerson</i>	MT Psych. Assoc	365	✓	
<i>Robert L. Jones</i>	MT Ch NASW	365	✓	
<i>Anita Bennett for Bill McDonald</i>	MA HCP ^{his testimony} _{turn in}	365	✓	
<i>Rick Patton</i>	MT Lr Citizens Assoc	365	✓	
<i>Ed GARRATT</i>	M.M.B.P.	365	✓	
<i>Tom Hopgood</i>	HIAT	365	✓	

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PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MINUTES

MONTANA SENATE 55th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE, & SAFETY

Call to Order: By CHAIRMAN STEVE BENEDICT, on February 21, 1997,
at 3:20 PM, in Room 410.

ROLL CALL

Members Present:

Sen. Steve Benedict, Chairman (R)
Sen. James H. "Jim" Burnett, Vice Chairman (R)
Sen. Larry L. Baer (R)
Sen. Chris Christiaens (D)
Sen. Bob DePratu (R)
Sen. Eve Franklin (D)

Members Excused: Sen. Dorothy Eck (D)
Sen. Sharon Estrada (R)
Sen. Fred Thomas (R)

Members Absent: None

Staff Present: Susan Fox, Legislative Services Division
Karolyn Simpson, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Executive Action: SB 338, SB 365

*{Tape: 1; Side: A; Approx. Time Count: 3:20 PM; Comments: some
comments unintelligible due to paper shuffling, room noise &
voices}*

EXECUTIVE ACTION ON SB 338

Motion: SENATOR JIM BURNETT moved SB 338 DO PASS.

Motion: SENATOR CHRIS CHRISTIAENS moved the AMENDMENTS
(SB033801.asf) DO PASS. (EXHIBIT 1)

Discussion: Susan Fox said amendment 3, exempts certain
facilities and are defined later in the bill from larger ones,
and amendment 4 exempts establishments that have 8 or less people
at one time. Amendment 7 (page 3, line 27) the Department of
Health may adopt rules, and amendment 9 returns it to annual
licensure, and adds bed and breakfasts if the bed and breakfast
bill doesn't pass. Because of the return to annual license, sub

section 5 is being deleted and section 6, allows for annual licensure.

SENATOR EVE FRANKLIN asked **Page Dringman** to comment on the amendments.

Page Dringman said these amendments are alright, agreed with **SENATOR CHRISTIAENS** that bed and breakfasts should be treated the same because there are a lot of small facilities serving 8 or less, and probably there is no big health safety problem.

SENATOR BAER said amendment 4, page 2, line 10, new language says "provide sleeping accommodations for 9 or more persons at one time." He asked if "provide sleeping accommodations for 9 or more clients" wouldn't be better language.

Page Dringman said yes, if it would be a point of confusion because it is 9 or more guests, not including family that may own or operate the place.

CHAIRMAN BENEDICT asked the committee if everyone agreed to that amendment. The answer was affirmative.

Vote: The DO PASS motion for the AMENDMENTS (SB033801.asf) CARRIED UNANIMOUSLY.

Amendments: **SENATOR CHRISTIAENS** said he has another amendment that was going into the bed and breakfast bill but introducing it for SB 338, page 4, following line 2, for the Department to develop guidelines for county sanitarians to ensure uniform application of rules because this has been a state-wide problem for bed and breakfasts.

Vote: **SENATOR CHRISTIAENS** moved the amendment for the Department to develop guidelines for county sanitarians DO PASS.

Discussion: **CHAIRMAN BENEDICT** asked **Kathleen Martin** if this amendment would place an undue burden on for the Department of Health and require 3 FTE's, a computer, etc.

Kathleen Martin said it would not place a burden on the Department and that was the intent of the bed and breakfast bill and thinks this is a good amendment.

Vote: The DO PASS motion for the AMENDMENT to page 4, CARRIED UNANIMOUSLY.

Motion: **SENATOR BAER** moved SB 338 AS AMENDED DO PASS. The motion carried UNANIMOUSLY (proxy votes from SENATORS ECK, ESTRADA, THOMAS)

EXECUTIVE ACTION ON SB 365

Motion: **SENATOR BAER** moved SB 365 DO PASS.

Motion: SENATOR BAER moved the Benedict amendments (SB036501.asf) to SB 365 DO PASS. (EXHIBIT 2)

Amendments: Susan Fox explained the amendments, saying the small managed care plans must consist of standards that are appropriate for quality assurance in Montana and can choose whichever HEDIS standards are appropriate.

CHAIRMAN BENEDICT told the committee if they have any questions about any of the amendments, feel free to ask them at any time.

Susan Fox explained amendment #5, page 10, line 23, tells the purpose is to provide a streamlined and simplified process for monitoring for compliance.

CHAIRMAN BENEDICT said this amendment puts the board back into the bill in the year 2001 to protect people of Montana from any fears that the administration, a new commissioner, or a new governor would not be able to work together.

Susan Fox explained the remaining amendments.

Vote: The DO PASS motion for CHAIRMAN BENEDICT's AMENDMENTS (SB036501.asf) to SB 365 CARRIED UNANIMOUSLY with SENATORS ECK, ESTRADA, and THOMAS voting by proxy.

Amendments: SENATOR FRANKLIN said she has an amendment that puts in some consumer mechanism, but will withdraw that because the board is being put back into the bill.

CHAIRMAN BENEDICT said he has another set of amendments (SB036503.asf) for provider-sponsored organizations. These are hospitals and physicians and other providers who organize for the purposes of securing contracts from payers who provide health care services, and are essentially the same as an HMO but would not be under HMO regulations. They should at least be referenced in the bill that defines what a provider-sponsored organization is. (EXHIBIT 3)

Motion/Vote: SENATOR BAER moved the AMENDMENTS (SB036503.asf) to SB 365 DO PASS. The motion CARRIED UNANIMOUSLY with SENATORS ECK, ESTRADA and THOMAS voting by proxy.

Discussion: SENATOR CHRISTIAENS asked what would have to change to trigger a report, and there were questions during the hearing about a material change.

Susan Fox said material change is not defined any where in the statutes but is used in quite a few places, specifically in the insurance codes and HMO codes. In business and the insurance community, it means any change of substance, but could be left to interpretation. But, because the Department has rule-making authority in this area, they can define this term through rules.

SENATOR CHRISTIAENS said it is important that be talked about so the Department will know that was not left out of the discussion. He expressed his concerns that a reference to durable medical equipment was not included in SB 128 and is missing in SB 365. At some point, or some bill, that issue should be addressed.

CHAIRMAN BENEDICT said durable medical equipment is not mentioned because that would be a mandated benefit and he would not ask for it to be included in SB 365.

Motion: **SENATOR BAER** moved SB 365 DO PASS AS AMENDED.

Discussion: **SENATOR EVE FRANKLIN** said she likes the provider and consumer board are back in the bill and will vote for SB 365, but is close in text to SB 128.

Vote: The DO PASS motion for SB 365 AS AMENDED CARRIED UNANIMOUSLY, with **SENATORS ECK, ESTRADA, and THOMAS** voting by proxy.

DATE 5/21/97

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Amendments to Senate Bill No. 365
First Reading Copy

Requested by Senator Benedict
For the Committee on Public Health, Welfare, and Safety

Prepared by Susan Byorth Fox
February 21, 1997

1. Title, line 12.
Following: "ORGANIZATIONS;"
Insert: "CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY
ASSURANCE EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND
DUTIES OF THE BOARD;"
2. Title, line 13.
Following: "DATES"
Insert: ", "
Strike: "AND"
Following: "DATE"
Insert: ", AND A TERMINATION DATE"
3. Statement of intent, Page 1, lines 26 and 27.
Following: "are" on line 26
Strike: "at" on line 26 through "be" on line 27
4. Statement of intent, Page 1, line 29.
Following: "department"
Insert: "and subsequently the board of network adequacy and
quality assurance"
5. Page 10, line 23.
Following: "compliance"
Insert: "through coordinated efforts of the commissioner and the
department [and the board]"
6. Page 13, line 12.
Following: "commissioner"
Insert: "[or to the board]"
7. Page 14, lines 12 and 13.
Strike: subsection (4) in its entirety
Renumber: subsequent subsections
8. Page 14, lines 15 and 17.
Strike: "(7)"
Insert: "(6)"
9. Page 15, line 22.
Insert: "(7) The department shall ensure timely and expedited
review and approval of the access plan and other
requirements in this section."
10. Page 15, lines 24 through 27.

Strike: subsection (1) in its entirety
Renumber: subsequent subsections

11. Page 16, lines 22 and 27.

Strike: "(2) and (3)"

Insert: "(1) and (2)"

12. Page 20, line 25.

Following: "allow the"

Insert: "commissioner and the"

13. Page 25, line 16.

Following: "department"

Insert: "[or the board]"

14. Page 25, line 18.

Following: "department"

Insert: "[or the board]"

15. Page 25, line 19.

Strike: "The"

Insert: "At the recommendation of the department [or the board]
the"

16. Page 25, line 20.

Following: "department"

Insert: "[or the board]"

17. Page 25, line 24.

Following: "department"

Insert: "[or the board]"

18. Page 26.

Following: line 6

Insert: "

NEW SECTION. **Section 30. Definitions.** As used in [sections 8 through 29], the following definitions apply:

(1) "Board" means the board of network adequacy and quality assurance provided for in [section 31].

(2) "Closed plan" means a managed care plan that requires covered persons to use only participating providers under the terms of the managed care plan.

(3) "Combination plan" means an open plan with a closed component.

(4) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(5) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating in a health benefit plan.

(6) "Department" means the department of public health and human services established in 2-15-2201.

(7) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention

could reasonably be expected to result in any of the following:

- (a) the covered person's health would be in serious jeopardy;
 - (b) the covered person's bodily functions would be seriously impaired; or
 - (c) a bodily organ or part would be seriously damaged.
- (8) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.
- (9) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.
- (10) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.
- (11) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.
- (12) "Health care provider" or "provider" means a health care professional or a facility.
- (13) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- (14) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.
- (15) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.
- (16) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.
- (17) "Medically necessary" means services or supplies that are necessary and appropriate for the treatment of a covered person's emergency medical condition or for the preventive care of a covered person according to accepted standards of medical practice.
- (18) "Network" means the group of participating providers that provides health care services to a managed care plan.
- (19) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial

incentives, for covered persons to use participating providers under the terms of the managed care plan.

(20) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(21) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

(22) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

(23) "Quality assurance" means quality assessment and quality improvement.

(24) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care services within a health plan.

NEW SECTION. **Section 31. Board of network adequacy and quality assurance.** (1) There is a board of network adequacy and quality assurance. The board is composed of a medical director, the director of the department of public health and human services, provided for in 2-15-2201, and the commissioner of insurance, provided for in 2-15-1903.

(2) The medical director is appointed by the governor and must be licensed as a physician by the state of Montana. The medical director must be a specialist in either family practice or internal medicine. The governor may remove a medical director at any time and appoint a new medical director to the position.

(3) The general powers and duties of the board are provided in [section 32].

(4) The board is attached for administrative purposes to the department pursuant to 2-15-121.

NEW SECTION. **Section 32. Board -- general powers and duties.** The board shall:

(1) periodically review the state network adequacy and quality assurance standards provided in [sections 8 through 29] and the rules implementing [sections 8 through 29];

(2) recommend corrective action necessary for the health carrier to achieve compliance with state network adequacy and quality assurance standards; and

(3) recommend action to the commissioner against a health carrier whose managed care plan does not comply with standards for network adequacy and quality assurance adopted by the board."

Renumber: subsequent sections

Strike: "29"
Insert: "32"

20. Page 26, line 24.
Strike: "and 30 through 32"
Insert: ", 33 through 35, and 37"

21. Page 26, line 26.
Insert: "(4) [Sections 30 through 32] and the language in
brackets in [sections 9, 12, and 28] are effective July 1,
2001.

NEW SECTION. Section 37. Termination. [Section 10]
terminates June 30, 2001."

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Amendments to Senate Bill No. 365
First Reading Copy

Requested by Senator Benedict
For the Committee on Public Health, Welfare, and Safety

Prepared by Susan Byorth Fox
February 21, 1997

1. Page 5, line 7.

Following: "organizations."

Insert: "This term applies to provider-sponsored organizations that directly assume risk or provide services directly to customers through contracts with employers or purchasing cooperatives."

2. Page 5.

Following: line 25

Insert: "(12) "Provider-sponsored organization" means an organization of physicians, hospitals, and other providers that are organized for the purpose of securing contracts with payers to provide health care services. The term includes a physician-hospital organization, a physician-sponsored network, a physician group practice, and a hospital-physician organization."

Renumber: subsequent subsection



SENATE STANDING COMMITTEE REPORT

Page 1 of 6
February 22, 1997

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill 365 (first reading copy -- white), respectfully report that Senate Bill 365 be amended as follows and as so amended do pass.

Signed: _____

Senator Steve Benedict, Chair

That such amendments read:

1. Title, line 12.

Following: "ORGANIZATIONS;"

Insert: "CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;"

2. Title, line 13.

Following: "DATES"

Insert: ", "

Strike: "AND"

Following: "DATE"

Insert: ", AND A TERMINATION DATE"

3. Statement of intent, Page 1, lines 26 and 27.

Following: "are" on line 26

Strike: "at" on line 26 through "be" on line 27

4. Statement of intent, Page 1, line 29.

Following: "department"

Insert: "and subsequently the board of network adequacy and quality assurance"

5. Page 5, line 7.

Following: "organizations."

Insert: "This term applies to provider-sponsored organizations that directly assume risk or provide services directly to customers through contracts with employers or purchasing cooperatives."

6. Page 5.

Following: line 25

Insert: "(12) "Provider-sponsored organization" means an

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organization of physicians, hospitals, and other providers that are organized for the purpose of securing contracts with payers to provide health care services. The term includes a physician-hospital organization, a physician-sponsored network, a physician group practice, and a hospital-physician organization."

Renumber: subsequent subsection

7. Page 10, line 23.

Following: "compliance"

Insert: "through coordinated efforts of the commissioner and the department [and the board]"

8. Page 13, line 12.

Following: "commissioner"

Insert: "[or to the board]"

9. Page 14, lines 12 and 13.

Strike: subsection (4) in its entirety

Renumber: subsequent subsections

10. Page 14, lines 15 and 17.

Strike: "(7)"

Insert: "(6)"

11. Page 15, line 22.

Insert: "(7) The department shall ensure timely and expedited review and approval of the access plan and other requirements in this section."

12. Page 15, lines 24 through 27.

Strike: subsection (1) in its entirety

Renumber: subsequent subsections

13. Page 16, lines 22 and 27.

Strike: "(2) and (3)"

Insert: "(1) and (2)"

14. Page 20, line 25.

Following: "allow the"

Insert: "commissioner and the"

15. Page 25, line 16.

Following: "department"

Insert: "[or the board]"

16. Page 25, line 18.

Following: "department"

Insert: "[or the board]"

17. Page 25, line 19.

Strike: "The"

Insert: "At the recommendation of the department [or the board]
the"

18. Page 25, line 20.

Following: "department"

Insert: "[or the board]"

19. Page 25, line 24.

Following: "department"

Insert: "[or the board]"

20. Page 26.

Following: line 6

Insert: "

NEW SECTION. **Section 30. Definitions.** As used in [sections 8 through 29], the following definitions apply:

(1) "Board" means the board of network adequacy and quality assurance provided for in [section 31].

(2) "Closed plan" means a managed care plan that requires covered persons to use only participating providers under the terms of the managed care plan.

(3) "Combination plan" means an open plan with a closed component.

(4) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(5) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating in a health benefit plan.

(6) "Department" means the department of public health and human services established in 2-15-2201.

(7) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(8) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(9) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or

other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(10) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(11) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

(12) "Health care provider" or "provider" means a health care professional or a facility.

(13) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(14) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

(15) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

(16) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(17) "Medically necessary" means services or supplies that are necessary and appropriate for the treatment of a covered person's emergency medical condition or for the preventive care of a covered person according to accepted standards of medical practice.

(18) "Network" means the group of participating providers that provides health care services to a managed care plan.

(19) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

(20) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide

health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(21) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

(22) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

(23) "Quality assurance" means quality assessment and quality improvement.

(24) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care services within a health plan.

NEW SECTION. **Section 31. Board of network adequacy and quality assurance.** (1) There is a board of network adequacy and quality assurance. The board is composed of a medical director, the director of the department of public health and human services, provided for in 2-15-2201, and the commissioner of insurance, provided for in 2-15-1903.

(2) The medical director is appointed by the governor and must be licensed as a physician by the state of Montana. The medical director must be a specialist in either family practice or internal medicine. The governor may remove a medical director at any time and appoint a new medical director to the position.

(3) The general powers and duties of the board are provided in [section 32].

(4) The board is attached for administrative purposes to the department pursuant to 2-15-121.

NEW SECTION. **Section 32. Board -- general powers and duties.** The board shall:

(1) periodically review the state network adequacy and quality assurance standards provided in [sections 8 through 29] and the rules implementing [sections 8 through 29];

(2) recommend corrective action necessary for the health carrier to achieve compliance with state network adequacy and quality assurance standards; and

(3) recommend action to the commissioner against a health carrier whose managed care plan does not comply with standards for network adequacy and quality assurance adopted by the board."

Renumber: subsequent sections

21. Page 26, lines 10 and 11.

Strike: "29"

Insert: "32"

22. Page 26, line 24.

Strike: "and 30 through 32"

Insert: ", 33 through 35, and 37"

23. Page 26, line 26.

Insert: "(4) [Sections 30 through 32] and the language in brackets in [sections 9, 12, and 28] are effective July 1, 2001.

NEW SECTION. **Section 37. Termination.** [Section 10]
terminates June 30, 2001."

-END-



MONTANA STATE SENATE

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MONTANA SENATE COMMITTEE PROXY

DATE 2-2-97

I request to be excused from the _____
Committee meeting this date because of other commitments. I desire
to leave my proxy vote with _____.

Indicate **Bill Number** and your vote **Aye** or **No**. If there are
amendments, list them by **name and number** under the bill and
indicate a **separate vote** for each amendment.

W/ Sen Benedict

HOUSE BILL/AMENDMENT	AYE	NO

SENATE BILL/AMENDMENT	AYE	NO
SB 365	✓	
SB 334	✓	

AND AMENDMENTS - BENEDICT

SEN.  _____
(Signature)

SEN:1997
WP/PROXY

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
55th LEGISLATURE - REGULAR SESSION**

COMMITTEE ON HUMAN SERVICES

Call to Order: By CHAIRMAN DUANE GRIMES, on March 21, 1997, at 3:00 P.M., in ROOM 104.

ROLL CALL

Members Present:

Rep. Duane Grimes, Chairman (R)
Rep. Loren L. Soft, Vice Chairman (Majority) (R)
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)
Rep. Darrel Adams (R)
Rep. Ellen Bergman (R)
Rep. William E. Boharski (R)
Rep. John C. Bohlinger (R)
Rep. Bill Carey (D)
Rep. Deb Kottel (D)
Rep. Billie Krenzler (D)
Rep. Brad Molnar (R)
Rep. Wes Prouse (R)
Rep. Diane Sands (D)
Rep. Bruce T. Simon (R)
Rep. Liz Smith (R)

Members Excused: Rep. Ahner

Members Absent: None

Staff Present: David Niss, Legislative Services Division
Jaelene Racicot, Committee Secretary

Committee Business Summary:

Hearing(s) & Date(s) Posted: SB 365 & HB 608
Executive Action: None

HEARING ON SB 365

Opening Statement by Sponsor:

SEN. STEVE BENEDICT, SD 30, introduced the bill. {Tape: 1; Side: A; Approx. Time Count: .3; Comments: SEN. BENEDICT explained the amendments and handed in an exhibit; see EXHIBIT 1.}

REP. KRENZLER questioned SEN. BENEDICT. {Tape: 1; Side: A; Approx. Time Count: 7.6.}

REP. SQUIRES questioned David Niss. {Tape: 1; Side: A; Approx. Time Count: 8.6.}

Proponents' Testimony:

Nancy Ellery, Department of Public Health and Human Services. {Tape: 1; Side: A; Approx. Time Count: 11.0.}

Claudia Clifford, State Auditor's Office. {Tape: 1; Side: A; Approx. Time Count: 16.5; Comments: Ms. Clifford offered an amendment.}

Jim Ahrens, President of the Montana Hospital Association. {Tape: 1; Side: A; Approx. Time Count: 22.3.}

Rep. Grimes submitted EXHIBIT 2 for the committee's consideration. {Tape: 1; Side: A; Approx. Time Count: 27.3.}

Marilyn Hudson, self. {Tape: 1; Side: A; Approx. Time Count: 27.4.}

Jerry Loendorf, Montana Medical Association. {Tape: 1; Side: A; Approx. Time Count: 29.0; Comments: Mr. Loendorf offered an amendment.}

Gloria Hermanson, Montana Psychological Association. {Tape: 1; Side: B; Approx. Time Count: 0; Comments: Ms. Hermanson offered an amendment.}

Mary McCue, Montana Dental Association and Licensed Professional Counselor. {Tape: 1; Side: B; Approx. Time Count: 1.3.}

Robert Torres, Montana Association of Social Workers. {Tape: 1; Side: B; Approx. Time Count: 2.1.}

Joyce Brown, Department of Administration. {Tape: 1; Side: B; Approx. Time Count: 2.9; Comments: Ms. Brown supported SEN. BENEDICT'S amendment.}

Al Smith, Montana Advocacy Program. {Tape: 1; Side: B; Approx. Time Count: 4.0; Comments: Mr. Smith offered amendments.}

Kip Smith, Montana Primary Care Association. {Tape: 1; Side: B; Approx. Time Count: 5.7; Comments: Mr. Smith offered amendments.}

Andrea Merrill, Mental Health Association of Montana. {Tape: 1; Side: B; Approx. Time Count: 10.2; Comments: Ms. Merrill went on the record in support of the State Auditor's and SEN. BENEDICT'S amendment.}

Barbara Booher, Montana Nurses Association. {Tape: 1; Side: B; Approx. Time Count: 11.0.}

Tom Ebzery, Yellowstone Community Health Plan. {Tape: 1; Side: B; Approx. Time Count: 11.7.}

Susan Good, Heal Montana and Montana Life Underwriters Association. {Tape: 1; Side: B; Approx. Time Count: 14.1.}

Tanya Ask, Blue Cross/Blue Shield. {Tape: 1; Side: B; Approx. Time Count: 16.5; Comments: See EXHIBIT 3 & 4.}

Tom Hopgood, Health Insurance Association of America. {Tape: 1; Side: B; Approx. Time Count: 18.9.}

Opponents' Testimony:

None

Questions From Committee Members and Responses:

{Tape: 1; Side: B; Approx. Time Count: 19.6.}

Closing by Sponsor:

SEN. BENEDICT closed. {Tape: 1; Side: B; Approx. Time Count: 27.3.}

HEARING ON HB 608

Opening Statement by Sponsor:

REP. LOREN SOFT, HD 12, introduced the bill. {Tape: 2; Side: A; Approx. Time Count: 0.}

Proponents' Testimony:

REP. KIM GILLAN, HD 11. {Tape: 2; Side: A; Approx. Time Count: 4.5; Comments: See EXHIBITS 5, 6, & 7.}

Rose Hughes, self. {Tape: 2; Side: A; Approx. Time Count: 9.3.}

Janet Croy, Little Rascals Preschool. {Tape: 2; Side: A; Approx. Time Count: 14.6.}

Cassie Pence, Kid Kollege Preschool. {Tape: 2; Side: A; Approx. Time Count: 17.6; Comments: See EXHIBIT 8.}

Shelly Boucher, Community Day Care. {Tape: 2; Side: A; Approx. Time Count: 19.2; Comments: See EXHIBIT 9.}

Montana State Senate



SENATOR STEVE BENEDICT

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The Big Sky Country

EXHIBIT 1
DATE 3-21-97
SB 365

COMMITTEES:
PUBLIC HEALTH, WELFARE & SAFETY
CHAIRMAN
BUSINESS & INDUSTRY, VICE-CHAIRMAN
LABOR

HOUSE HUMAN SERVICES COMMITTEE March 21, 1997

STATEMENT OF SENATOR STEVE BENEDICT CHIEF SPONSOR SENATE BILL 365

This statement demonstrates the legislative intent of SB 365 and in particular, the legislative intent of Section 3, which amends § 33-31-102, MCA.

It is my intention that this bill apply to all managed care organizations. I believe that all of the parties involved in preparing SB 365 share that understanding.

I want it to be clear that the legislative history reflects that it is the intent of this legislature that the provisions of SB 365 do apply to provider-sponsored organizations that assume insurance risk. That was the intent all along and that is what the plain, clear and unambiguous language of the bill states.

I ask that you enter my written statement in the minutes.

A handwritten signature of Steve Benedict in cursive script.

Steve Benedict
Sponsor, Senate Bill 365

APPENDIX A

GLOSSARY OF HEALTH CARE TERMS

Adverse Selection. A tendency for utilization of health services in a population group to be higher than expected or estimated; for example, when persons with poorer-than-average health status apply for or continue to receive insurance coverage to a greater extent than persons with average or better health expectations.

Alternative Care. The whole range of health, nutritional, housing and social services which keep persons out of institutions and allow them to function in the home and community environment. Usually focused on the aged, physically disabled and developmentally disabled.

Canadian Plan. A single payer system, Canada's national health insurance system covers all Canadians' hospital care, outpatient care and some prescription drugs. Thirty-eight percent of the system is financed by national taxation, 62 percent by provincial taxation. Private doctors in fee-for-service practices bill Provincial Health Ministries monthly, and trustee- or community-owned hospitals negotiate annual budgets with provincial governments. The government sets rates limiting the fees that providers can charge for their services.

Capitation. Often used by health maintenance organizations (HMOs), capitation is a payment method in which a physician or hospital is paid a fixed amount per patient per year regardless of the services the patient requires.

Case Management. A method of handling patients under managed care systems, such as HMOs. It is also known as "gatekeeping". A primary care practitioner is responsible for determining the quantity and mix of services a patient requires, including access to specialists or alternative treatments.

Certificate of Need (CON). A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. It is meant to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

CHAMPUS. An acronym for the Civilian Health and Medical Program of the Uniformed Services. CHAMPUS is the health insurance program that serves the dependents of active-duty military personnel as well as retired military personnel and their dependents. Health care for active duty personnel is provided by the Defense Department.

Coinsurance. A percentage of health care costs not covered by medical insurance that individuals must pay. For example, many insurance plans pay 80 percent of hospital and doctors' costs with the individual responsible for the remaining 20 percent.

Community Rating. A method of determining the annual cost of health insurance premiums. A community rating premium is based on the average medical cost for all covered people in a geographical area. It does not consider any one person's medical condition or history. Community rating usually keeps health care costs relatively low because the method factors a large pool of people into the premium equation.

Copayment (copay). A cost-sharing mechanism requiring individuals to pay a fixed amount (usually \$5 or \$10) for pre-determined health care services at the time they obtain the service regardless of the cost of the service.

Cost Containment. A set of steps to control or reduce inefficiencies in the consumption, allocation, or production of health care services which contribute to higher than necessary costs.

Cost Sharing. A health insurance provision that requires individuals to cover some part of their medical expenses. Examples include coinsurance, copayments, and deductibles. Cost sharing may help hold down the costs by deterring individuals from seeking unnecessary care.

Cost Shifting. The practice of shifting health care costs from persons who are uninsured onto persons who are well-insured. For example, if Medicaid does not pay a hospital the full cost of caring for a person with pneumonia, the hospital must recover its loss by charging someone with a comprehensive insurance policy more than the usual cost of the services he or she receives.

Covered Services. Health care services covered by an insurance plan.

Current Population Survey (CPS). The Bureau of the Census in the U.S. Department of Commerce collects this data which provides a statistical analysis of such state and national characteristics as the numbers of people who are unemployed, or in this case, uninsured.

Deductible. The amount a patient must pay out of pocket before insurance will cover costs.

Diagnosis Related Groups (DRGs). A classification system designed to control costs and set standard Medicare payments. The payments are predetermined based on the patient disease, diagnosis, procedure, sex, age and medical history. After a physician determines what medical procedure or operation a Medicare beneficiary requires, Medicare reimburses the provider based on the system.

Employee Retirement Income Security Act (ERISA). A federal law that sets the standards of disclosure for employee benefit plans to ensure workers the right to at least part of their pension. The law governs most private pensions and other employee benefits and overrides all state laws that concern employee benefits, including health benefits. ERISA exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination and other health reforms.

Employer Mandate. An approach to universal coverage which requires an employer to provide and pay for all or a part of employees' health insurance costs.

Experience Rating. Setting health insurance premiums based on the historical costs of health care of the group or individual to be covered.

Fee-for-Service (FFS). A method of billing for health care services under which a physician or other provider charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of U.S. physicians. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.

Global Budgeting. An amount set by an administrative body that aims to control all health care costs. It usually covers spending by government and other insurance purchasers. Global budgets are most often associated with universal health insurance, in which all individuals of a country or state are covered.

Guaranteed Issue. A requirement that health insurers have to extend insurance coverage to any individual or family regardless of medical history or medical or occupational condition.

Guaranteed Renewal. A requirement for health insurers to renew health insurance for all individuals currently insured by the insurance company.

Health Care Facility. A facility or institution, whether public or private, proprietary or nonprofit, that offers diagnostic, treatment and inpatient or ambulatory care services to two or more unrelated persons. The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

Health Care Financing Administration (HCFA). An agency of the U.S. Department of Health and Human Services which administers Medicare, the health insurance program for the elderly and disabled, and Medicaid, the health insurance program for the poor.

Health Care Provider. A person or legal entity, other than a health care facility, licensed, certified or otherwise authorized by the laws of Montana to provide health care services in the ordinary course of business or practice of a profession.

Health Care Purchasing Pool. An entity which pools employers and consumers into a large purchasing group that can bargain with health plans for lower-cost insurance coverage.

Health Care Resource Management Plan. Pursuant to SB 285, a statewide determination of the distribution and allocation of health care resources in Montana.

Health Maintenance Organization (HMO). A prepaid health care plan in which an individual pays the HMO a set amount, usually on a monthly basis, and seeks treatment from affiliated medical staff. The goal is to provide affordable health care through managed care, a system in which a primary care provider acts as a gatekeeper to specialists and expensive medical tests. In general, subscribers pay a small copay at each visit. Under such plans, patients typically have a limited choice of doctors.

Health Professional Shortage Areas (HPSAs). An area which the U.S. Department of Health and Human Services designates as having a seriously inadequate supply of health care personnel. Forty-one of Montana's 56 counties are designated as HPSAs.

Indian Health Service (IHS). A federal agency of the Public Health Service within the Department of Health and Human Services which delivers and/or pays for health services for American Indians or Alaska Natives. Health services are either obtained in IHS, urban, or tribal-operated health clinics, or on a contractual basis with other existing providers.

Look Back. A health insurance policy may exclude coverage for a treated medical condition that occurred within a specified time period (five years under Montana law). Coverage of the condition may only be excluded as a pre-existing condition for a specified amount of time (12 months in Montana).

Managed Care. A type of health care delivery which aims to control costs by using "gatekeepers" -- primary care doctors or caseworkers -- to coordinate patients' use of health services. Managed care networks usually are organized by insurance companies, employers, or hospitals. One such network is the type run by health maintenance organizations, in which a patient sees one physician who determines the medical care, both general and specialized, that the patient will receive.

Medicaid. A federally aided and state operated and administered program that provides medical benefits to low-income persons or persons with certain medical conditions. Minimum benefit requirements are set by the federal government.

Medically Underserved Areas (MUAs). A federally developed measure identifying areas that are critically underserved. A number of factors are considered: the proportion of the population below poverty, the percentage of the population over 65, and the primary care physician-to-population ratio. Over half of Montana's counties are designated as MUAs.

Medicare. A national health insurance program that pays for hospitalization, medical care and some related services for people over age 65, people who have received Social Security disability insurance payments for two years or longer, and people with end-stage renal disease.

Mental Illness. All forms of illness in which psychological, emotional or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought and definitions. It includes a wide range of disorders (such as psychosis, neurosis, and organic brain syndrome and severities).

Multiple Payer Plan. A method of financing health services through premiums, which would be paid to organizations that would process all claims and payments.

Nurse Practitioners. A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities and other health care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his or her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for-service reimbursement for their services.

Out-of-Pocket Expenses. Any health care costs that are assumed directly by the patient. Examples of such expenses include copayments and deductibles.

Outcomes Analysis. An evaluation system associated with managed competition that rates medical treatments according to outcomes or success rates. For a health care plan to qualify to offer its services to consumers, the doctors and hospitals in the plan must show average or better results.

Physician's Assistant (PA). A specially trained and licensed or otherwise credentialed individual who performs tasks which might otherwise be performed by a physician under the direction of a supervising physician. The PA is also known as a physician extender and by many other essentially synonymous terms.

Physician Hospital Organization (PHO). A variation of the HMO, in which a group of doctors with a strong loyalty to a particular hospital, but who are not usually the medical staff of the hospital, offer services to their community based upon common goals, values and a shared vision for health care in their community

"Play or Pay". A universal coverage plan in which employers either provide their workers with a basic health benefits package, or pay into a government insurance pool.

Portability. The ability for an individual to maintain health insurance coverage regardless of job status. It typically allows an individual to transfer from one health insurer to another without regard to pre-existing conditions or other risk factors.

Practice Protocols. Systematically developed strategies to assist physicians in clinical decisionmaking. These are parameters designed to improve quality and assure appropriate utilization of health services (also known as practice guidelines and practice parameters).

Pre-Existing Condition. A physical or mental condition diagnosed before an individual receives health insurance coverage. Some insurers refuse coverage because of such a condition. Others may increase their rates or refuse to cover the patient for a specific time.

Preferred Provider Organization (PPO).

Under this contract system, providers, usually organized by "networks" or panels, give medical care for a set fee. Various benefits, such as lower coinsurance and better coverage create incentives for patients to see "preferred" physicians. Under some PPO plans, individuals are able to visit non-PPO physicians for a higher cost, the providers are compensated directly by an insurance company and copayments. Not all PPOs cover visits to non-PPO physicians.

Premium. The periodic amount that individuals or families must pay for an insurance policy.

Preventive Care. A form of health care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). With increasing knowledge of nutritional, malignant and other chronic diseases, the scope of preventive medicine has been extended. It is now assumed that most, if not all, medical problems are preventable at some stage of their development. The promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.

Primary Care. Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

Primary Care Physician. A practitioner who focuses on basic or general health care, ideally at the point where a patient first seeks assistance from the health care system. Primary care is considered comprehensive when the provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral or social.

Rate Setting. The system a government uses to reimburse doctors and hospitals for services. It implies strict control of costs. Under Medicare, the government has a complicated reimbursement formula that takes into account the procedure and the provider's cost.

Rationing. Any system that limits the amount of health care that a person can receive. For example, Oregon has developed a system which ranks medical procedures and conditions and provides Medicaid coverage only to a certain point on the priority list. Some health care analysts argue that rationing currently exists, based on income.

Regulated Multiple Payer System. This is one of the health care financing methods being considered by the state of Montana in which health care services are financed through a mix of public and private funds so that each resident of the state receives a uniform set of benefits as established by statute or administrative rule. State government has the responsibility for regulating the multiple entities that provide benefits to residents, including regulations for enrollment, change in premium rate, payment rate to providers, and aggregate health expenditure.

Reimbursement. The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

Reinsurance. Coverage purchased by a health plan from an insurance company to reimburse the plan for the cost of benefits paid out to an individual or an account that has exceeded what the plan expected to pay out. It stops the insurance company's loss. It is also known as stop-loss coverage or risk-control insurance.

Resource-based Relative Value Scale (RBRVS). A fee schedule used by Medicare for reimbursing all health care services obtained from individual providers. The RBRVS system evaluates all health care services, assigns them different relative values, depending on the expertise and training necessary to render the service, the time involved, and other similar factors, and makes payments accordingly.

Self-Funding of Health Benefits. An employer or group of employers sets aside funds to cover the cost of health benefits for their employees. Benefits may be administered by the employer(s) or handled through an administrative service only agreement with an insurance carrier or third-party administrator.

Single Payer System. One of the health care financing methods being considered by the state of Montana in which health care services are financed through public funds so that each resident of the state receives a uniform set of benefits as established through statute or administrative rule. Policies governing all aspects of the management of the single payer system would reside with the state government and benefits must be administered by a single entity.

Small Group Market. In Montana, this refers to selling insurance to employer groups of three to 25 persons.

Subsidy. Monetary assistance provided by government to low income individuals to aid in purchasing health insurance and meeting out-of-pocket health care expenses. Subsidies for low income individuals are generally associated with health care systems that achieve universal coverage through individual mandates.

Third-Party Payer. Anyone paying for health care who is not the patient (the first party) or the care-giver (the second party). It includes public and private insurance providers such as Medicaid, Medicare, Blue Cross Blue Shield and most commercial health insurance companies. Generally, the patient pays a premium to the third party payer, and the third party payer then pays the bills — or a percentage of the bills — incurred by the patient.

Unbundle. The practice of billing components of an integral service separately for a higher reimbursement amount.

Uncompensated Care. Care given by a hospital or other care-giver that is not paid for by the patient, their insurance company, or the government. The cost of uncompensated care is often charged to paying patients and their insurance companies. It is sometimes also referred to as "charity" care.

Underinsured. Individuals or families with public or private insurance policies that do not cover all necessary medical services or that have significant cost sharing requirements that are likely to result in out-of-pocket expenses that exceed their ability to pay.

Uniform Benefit Package. The set of predetermined medical services which all health plans must provide to all individuals.

Uninsured. People who lack public or private health insurance.

Universal Coverage. A plan designed to give everyone in a country or state access

to health insurance. Ways to do that include employer mandates, single payer system and "play or pay" systems.

Sources

Adapted from Congressional Quarterly Weekly Report. "Health Care A to Z." Vol. 51, Supplement No. 38, September 25, 1993, pp. 56-66.

Alpha Center, "Glossary of Terms as Commonly Used in Health Care." September 1994.

State of Vermont Health Care Authority, *Universal Access Plans*. "Glossary." November 1, 1993.

Subcommittee on Health and the Environment of the Committee of Interstate and Foreign Commerce, U.S. House of Representatives, *A Discursive Directory of Health Care*. February 1976.

American Hospital Association, *Hospital Administration Terminology*.

Health and Life Sciences Division, Office of Technology Assessment, U.S. Congress, *Compilation of Acronyms and Terms*. August 1986.

Lee Hyde, M.D., *The McGraw-Hill Essential Dictionary of Health Care*. New York: McGraw-Hill Book Company, 1988.

Howard Larken, "Glossary of Medicare Terminology," *American Medical News*. July 6/13, 1992, pp. 17-20.

American Medical Association, *Advocacy Briefs, Health Care Reform Glossary*, December 1992.

Senate Bill 365
Managed Care Regulation-Network Adequacy
and Quality Assurance

House Human Services Committee

March 21, 1997

Testimony of Tanya Ask, Blue Cross and Blue Shield of Montana

Blue Cross and Blue Shield of Montana is a health service corporation licensed in the state of Montana to provide health care benefit financing - private insurance. We also administer health care benefits for self-funded groups. In total we serve is about 250,000 Montanans for their health care benefits and expenses. Approximately ten percent are in managed care.

In 1993 and 1995 this legislative body concentrated on making health benefits available to more people: small group reform, individual market modifications and guaranteed renewability, revision of the Montana Comprehensive Health Association, conversion modifications and pre-existing condition modifications. Last Friday you heard the state Health Insurance Portability and Accountability Compliance Act (SB 378), which also deals with availability issues.

Health care benefit consumers have been concerned with a second issue: cost. None of these measures which have been enacted were aimed at making health benefits or services more affordable.

Managed care, a market based initiative integrating health care delivery and financing is addressing the individual's and the purchaser's ability to afford health benefits. There are two operational managed care benefit initiatives in Montana, both Montana-based, HMO Montana and Yellowstone Community Health Plan. In the future, there will be more, and some of them may be large national organizations. Additional consumer choice and competition is good.

This legislation is intended to make sure any organization offering managed care health benefit plans to Montana residents operates in a responsible manner for the individuals receiving their health care through the organization.

* This legislation establishes a framework ensure health care provider networks are adequate to care for the individuals who are paying for services, or on whose behalf payment is made.

* This legislation ensures that, through regulatory oversight of the health carrier or insurer, that the coverage will be there when the individual needs it.

* This legislation establishes reporting and disclosure requirements.

* This legislation does something else which is implied in our health care system, but not measured, reviewed and communicated

EXHIBIT 4
DATE 3-21-97
SB 365

as will be required with SB 365 - it establishes a quality assurance mechanism, and quality assessment and improvement responsibilities.

There are many entities interested in managed care. Three are currently licensed and you have already heard two operational, and doing a good job for Montanans. We have heard there are many more who are interested. Regardless of where they come from - Hartford or Omaha, Sidney or Missoula, it is important Montanans have the benefit of knowing they have met the test of adequacy and quality.

This a major piece of legislation. It will not be inexpensive. It will be time consuming. We believe it is a responsible approach to managed care regulation for Montanans. To assure Montanans that they will have access to the quality care they may need, these standards must be applied to every entity that wishes to offer health benefits through a managed care network to Montana residents.

Amendments to Senate Bill No. 365
Third Reading Copy

Requested by Senator Steve Benedict
For the Committee on Human Services

Prepared by Susan Byorth Fox
March 18, 1997

1. Page 5, lines 14 through 17.
Following: "organizations." on line 14
Strike: the remainder of line 14 through line 17 in its entirety
2. Page 6, lines 6 through 10.
Strike: subsection (12) in its entirety
Renumber: subsequent subsection

Proposed Amendments
S.B. 365
Third Reading Copy
March 20, 1997

1. Page 12, line 26.

Following: "services"

Insert: ", medicines,"

Following: "appropriate for the"

Insert: "diagnosis or"

2. Page 12, line 27.

Strike: "emergency medical"

Insert: "illness, injury, or medical"

Strike: "or for the preventive care of a covered person"

3. Page 12, line 28.

Following: "practice"

Insert: "and are not provided only as a convenience"

Proposed Amendments to SB 365, Second Reading Copy

1. Page 5, lines 14-17.
Strike: "THIS TERM APPLIES" in line 14
Strike: lines 15, 16, and 17.
2. Page 6, lines 6-10.
Strike: lines 6 through 10.
Renumber: Subsequent subsection.
3. Page 17, line 9.
Preceding: "inpatient"
Insert: "acute care"
4. Page 17, line 9.
Preceding: "inpatient"
Insert: "acute care"

PROPOSED AMENDMENTS
Senate Bill 365

1. Page 18, line 29
Following: "A"
Strike: "health carrier and"
2. Page 18, line 30
Following: "notice to"
Strike: "each other"
Insert: "the health carrier"
3. Page 18, line 30
Following: "cause"
Insert: "A participating provider shall not be terminated without cause. Any decision of a health carrier to terminate a participating provider shall be subject to appeal of such decision by the participating provider to the Board of Network Adequacy and Quality Assurance. The ~~quality review council~~ ^{Board} shall hear the appeal after giving reasonable notice thereof to each party. The decision to terminate shall not be final unless it is approved by the Board of Network Adequacy and quality Assurance."

(Submitted by the Montana Psychological Association)

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

House Human Service

SUB-COMMITTEE

DATE *3-21-97*

BILL NO. _____ SPONSOR(S) _____

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
<i>Barbara Loocher</i>	<i>MNA</i>	<i>SB 365</i>	
<i>Kim Giller</i>	<i>HD 11</i>	<i>HB 608</i>	
<i>Ellen Feave</i>	<i>Holen Hcl AA</i>	<i>SB 365</i>	
<i>Joyce Brown</i>	<i>Dept of Administration</i>	<i>SB 365</i>	
<i>Marilyn Hudson</i>	<i>HHA/Private Business</i>	<i>SB 365</i>	
<i>TANYA Ask</i>	<i>Blue Coast Blue Shrub</i>	<i>SB 365</i>	
<i>Lanni Planger</i>	<i>DPHHS</i>	<i>SB 365</i>	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

House Human Services ~~SB~~-COMMITTEE

DATE *3-21-97*

BILL NO. _____ SPONSOR(S) _____

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Contrella Peterson 519 Fifth Avenue Laurel	Laurel Christian Day Care	Amend. X	
Cassie Pence 1030 Senora Billings 59105	Kid College Preschool Day Care	AMEND *	
Shelly Boucha 2975 Georgina Dr Billings 59102	Dir, Community Day Care	Amend *	
Ceryl Sharp 2335 Bolton Blvd Billings 59102	Parent, Community Day Care	Amend	
P.O. Box 21120 Billings, MT Janet Croy 59105	Lt. Hl. Kussals Preschool	Amend	
Tom Hepgood	Health Ins. Assoc. Amer	✓	
M Susan Croed	MALL 365	✓	
Jerry Loendorf	Rel. Med CES	Amend ✓	
Al Smith	Montana Advocacy Group	Amend ✓	
Kip Smith	MPCA	365 ✓	
Gloria Neumann	Mt Psych Assoc	365 ✓	
Andrea Merrill	Mental Health Assoc	SB 365 Amel.	
Tom Gitzky	YCHP	SB 365	
Nancy Elger	DPH+HS	SB 365	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

Ap. Smith

PROPOSED AMENDMENT TO SENATE BILL 365

March 21, 1997

Section 3. Section 33-31-102, MCA; Definitions

(7) "Health maintenance organization" means a person who provides or arranges for THE PROVISION OF basic health care services to enrollees on a prepaid or ~~other financial~~ partially prepaid basis, ~~either directly through provider employees or through contractual or other arrangements with a provider or group of providers~~ to participating providers in a network utilizing a closed plan or combination plan. ~~This subsection does not limit methods of provider payments made by health maintenance organizations. THIS TERM APPLIES TO PROVIDER SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING COOPERATIVES.~~

If this amendment is accepted, Section 3 will need to cross reference several definitions that already exist in Section 10 including "participating provider", "network", "closed plan", "combination plan", etc.

Section 1 Definitions

Page 3, Line 13

Subsection (5)

strike "~~or~~" after "services"

Insert after "services" **and products and supplies**

**Section 3 Definitions,
Page 4**

Subsection 1

Insert New Subsection (k)

Ancillary Services are those indirect medically related services which shall include but are not limited to:

1) Durable Medical Equipment, maintenance and repair,

2) Assistive Technology devices and services;

3) Oxygen and Respiratory Services;

4) Orthotics and Prosthetics;

5) Prescription drugs and medical supplies;

6) Home Health Services, both skilled and non-skilled;

7) Rehabilitation therapy and Clinics, to include occupational therapy, physical therapy, and speech therapy;

8) Home Modifications;

9) Medical Transportation;

Subsection 5(d)

Page 5, Line 7

insert after "other services" **products and supplies**

NEW SECTION, Section 10 Definitions

Page 12, Line 14

Subsection (12)

Insert after "services" **products and supplies**

Page 12, Line 26

Subsection (16)

Insert after "services" and strike "~~or~~" and insert and products and

Page 13, Line 8

Subsection (20)

Insert after "health care professional" , who may be a specialized provider,

NEW SECTION, Section 13

Page 14, Line 29

Subsection (3)

Insert after "the relative availability of" any willing

NEW SECTION, Section 30 Definitions

Page 28, Line 5

Subsection (13)

Insert after "services" and products and supplies

Page 28, Line 20

Subsection (17)

Strike "~~or~~" after "services"

Insert after "services" and products and supplies

Page 29, Line 4

Subsection (21)

Insert after "health care professional" [who may be a specialized provider,]

**HOUSE OF REPRESENTATIVES
ROLL CALL**

HUMAN SERVICES COMMITTEE

DATE 3-21-97

<u>NAME</u>	<u>PRESENT</u>	<u>ABSENT</u>	<u>EXCUSED</u>
Rep. Duane Grimes, Chairman	✓		
Rep. Loren Soft, Vice Chairman	✓		
Rep. Carolyn Squires, Vice Chairman	✓		
Rep. Darrel Adams	✓		
Rep. Chris Ahner			✓
Rep. Ellen Bergman	✓		
Rep. Bill Boharski	✓		
Rep. John Bohlinger	✓		
Rep. Bill Carey	✓		
Rep. Deb Kottel	✓		
Rep. Billie Krenzler	✓		
Rep. Brad Molnar	✓		
Rep. Wes Prouse	✓		
Rep. Diane Sands	✓		
Rep. Bruce Simon	✓		
Rep. Liz Smith	✓		

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 55th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES

Call to Order: By CHAIRMAN DUANE GRIMES, on March 27, 1997, at 5:00 P.M., in ROOM 104.

ROLL CALL

Members Present:

Rep. Duane Grimes, Chairman (R)
Rep. Loren L. Soft, Vice Chairman (Majority) (R)
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)
Rep. Darrel Adams (R)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. William E. Boharski (R)
Rep. John C. Bohlinger (R)
Rep. Bill Carey (D)
Rep. Deb Kottel (D)
Rep. Billie Krenzler (D)
Rep. Brad Molnar (R)
Rep. Wes Prouse (R)
Rep. Diane Sands (D)
Rep. Bruce T. Simon (R)
Rep. Liz Smith (R)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Services Division
Jaelene Racicot, Committee Secretary

Committee Business Summary:

Hearing(s) & Date(s) Posted: None
Executive Action: SB 378
SB 365 CONCUR IN AS AMENDED 16-0
SJR 16 CONCUR IN AS AMENDED 10-6

REP. GRIMES COMMENTED ON THE COMMITTEE DINNER. {Tape: 1; Side: A; Approx. Time Count: .3.}

IN ADDITION, REP. GRIMES HANDED OUT EXHIBIT 1, ON BEHALF OF NANCY ELLERY, FOR THE COMMITTEE'S CONSIDERATION.

EXECUTIVE ACTION ON SB 365

Motion: REP. BOHLINGER MOVED SB 365 BE CONCURRED IN. {Tape: 1; Side: A; Approx. Time Count: .9.}

Discussion:

REP. GRIMES. {Tape: 1; Side: A; Approx. Time Count: 1.0.}

Motion: REP. SIMON MOVED TO AMEND SB 365. {Tape: 1; Side: A; Approx. Time Count: 4.1.}

Discussion:

REP. KRENZLER. {Tape: 1; Side: A; Approx. Time Count: 4.4.}

REP. SIMON. {Tape: 1; Side: A; Approx. Time Count: 4.8.}

Vote: THE MOTION CARRIED WITH REP. BOHARSKI VOTING NO. {Tape: 1; Side: A; Approx. Time Count: 5.3.}

Motion: REP. AHNER MOVED SB 365 BE CONCURRED IN AS AMENDED. {Tape: 1; Side: A; Approx. Time Count: 5.4.}

Discussion:

REP. BOHARSKI. {Tape: 1; Side: A; Approx. Time Count: 5.6; Comments: Questioned REP. SIMON.}

REP. SIMON. {Tape: 1; Side: A; Approx. Time Count: 6.4.}

Motion: REP. SMITH MOVED THE GRIMES AMENDMENT. {Tape: 1; Side: A; Approx. Time Count: 7.6.}

Vote: THE MOTION CARRIED WITH REP. BOHARSKI VOTING NO. {Tape: 1; Side: A; Approx. Time Count: 8.6.}

Discussion:

REP. SIMON.

Motion: REP. SIMON MOVED THE GRIMES AMENDMENT. {Tape: 1; Side: A; Approx. Time Count: 10.0; Comments: REP. SIMON EXPLAINED THE AMENDMENT.}

Discussion:

REP. GRIMES. {Tape: 1; Side: A; Approx. Time Count: 11.5.}

Claudia Clifford. {Tape: 1; Side: A; Approx. Time Count: 12.6.}

REP. GRIMES. {Tape: 1; Side: A; Approx. Time Count: 13.2.}

REP. BOHARSKI. {Tape: 1; Side: A; Approx. Time Count: 14.2.}

Claudia Clifford. {Tape: 1; Side: A ; Approx. Time Count: 15.1.}

Jerry Loendorf. {Tape: 1; Side: A; Approx. Time Count: 15.5.}

Vote: THE MOTION CARRIED UNANIMOUSLY. {Tape: 1; Side: A;
Approx. Time Count: 15.9.}

Motion: REP. AHNER MOVED SB 365 BE CONCURRED IN AS AMENDED.
{Tape: 1; Side: A; Approx. Time Count: 16.1.}

Discussion:

REP. BOHARSKI. {Tape: 1; Side: A; Approx. Time Count: 16.2;
Comments: Questioned Jerry Loendorf.}

REP. GRIMES EXPLAINED AN AMENDMENT. {Tape: 1; Side: A; Approx.
Time Count: 18.0.}

Motion: REP. GRIMES MOVED THE GRIMES AMENDMENT. {Tape: 1; Side:
A; Approx. Time Count: 19.1.}

Discussion:

REP. SQUIRES. {Tape: 1; Side: A; Approx. Time Count: 20.8;
Comments: Questioned REP. GRIMES.}

REP. SQUIRES. {Tape: 1; Side: A; Approx. Time Count: 22.7;
Comments: Questioned Nancy Ellery.}

REP. CAREY. {Tape: 1; Side: A; Approx. Time Count: 23.9;
Comments: Questioned REP. GRIMES.}

REP. BOHARSKI. {Tape: 1; Side: A; Approx. Time Count: 24.8.}

Vote: THE MOTION CARRIED WITH REP. SQUIRES, REP. BOHLINGER, REP.
CAREY, REP. KOTTEL, AND REP. KRENZLER VOTING NO. {Tape: 1; Side:
A; Approx. Time Count: 25.3.}

Motion: REP. AHNER MOVED SB 365 BE CONCURRED IN AS AMENDED.
{Tape: 1; Side: A; Approx. Time Count: 25.4.}

Discussion:

REP. BOHARSKI. {Tape: 1; Side: A; Approx. Time Count: 25.5;
Comments: Questioned REP. SQUIRES.}

REP. GRIMES EXPLAINED ANOTHER GRIMES AMENDMENT. {Tape: 1; Side: A;
Approx. Time Count: 26.8.}

Motion: REP. GRIMES MOVED THE GRIMES AMENDMENT. {Tape: 1; Side:
A; Approx. Time Count: 28.6.}

Discussion:

REP. SIMON. {Tape: 1; Side: A; Approx. Time Count: 28.7.}

REP. KOTTEL. {Tape: 1; Side: A; Approx. Time Count: 30.1.}

REP. GRIMES. {Tape: 1; Side: B; Approx. Time Count: .8.}

REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 2.0;
Comments: Questioned REP. GRIMES.}

REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 3.5;
Comments: Questioned REP. SIMON.}

REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 5.4.}

Jerry Loendorf commented on the Grimes amendment. {Tape: 1;
Side: B; Approx. Time Count: 6.2.}

REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 7.1.}

WITHDREW MOTION: REP. GRIMES WITHDREW HIS AMENDMENT. {Tape: 1;
Side: B; Approx. Time Count: 7.8.}

Vote: THE MOTION CARRIED UNANIMOUSLY. {Tape: 1; Side: B; Approx.
Time Count: 8.2.}

EXECUTIVE ACTION ON SJR 16

Discussion: REP. GRIMES. {Tape: 1; Side: B; Approx. Time Count:
8.4.}

REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 11.6.}

REP. KOTTEL. {Tape: 1; Side: B; Approx. Time Count: 14.6.}

Motion/Vote: REP. BOHLINGER MOVED TO RECONSIDER ACTION ON SJR
16. A ROLL CALL VOTE WAS TAKEN. THE MOTION CARRIED 10 - 6
{Tape: 1; Side: B; Approx. Time Count: 15.9.}

Discussion:

REP. PROUSE. {Tape: 1; Side: B; Approx. Time Count: 16.9;
Comments: Questioned Mike Hanshew.}

REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 18.5.}

REP. BOHLINGER. {Tape: 1; Side: B; Approx. Time Count: 19.4.}

REP. ADAMS. {Tape: 1; Side: B; Approx. Time Count: 21.1.}

REP. AHNER. {Tape: 1; Side: B; Approx. Time Count: 22.0.}

1

HOUSE OF REPRESENTATIVES
ROLL CALL

HUMAN SERVICES COMMITTEE

DATE 3-27-97

NAME	PRESENT	ABSENT	EXCUSED
Rep. Duane Grimes, Chairman	✓		
Rep. Loren Soft, Vice Chairman	✓	✓	
Rep. Carolyn Squires, Vice Chairman	✓		
Rep. Darrel Adams	✓		
Rep. Chris Ahner			✓
Rep. Ellen Bergman	✓		
Rep. Bill Boharski	✓		
Rep. John Bohlinger	✓		
Rep. Bill Carey	✓		
Rep. Deb Kottel	✓		
Rep. Billie Krenzler	✓		
Rep. Brad Molnar	✓		
Rep. Wes Prouse	✓		
Rep. Diane Sands	✓		
Rep. Bruce Simon			✓
Rep. Liz Smith	✓		

**There are no vote sheets or exhibits on the
Law Library's CD provided by
Legislative Services for March 27, 1997.**

SENATE BILL NO. 365

INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD,
MASOLO, BAER, M. TAYLOR, MILLS, ROSE, MAHLUM, MOOD, SPRAGUE, JABS, ESTRADA,
DEPRATU, FOSTER, MCNUTT, KEATING, JENKINS, CRISMORE, GLASER, HERTEL, BURNETT,
THOMAS, SMITH, CRIPPEN, COLE, BOHLINGER, PECK, DENNY, OHS, GRINDE, BOOKOUT-REINICKE,
BARNETT, MARSHALL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE
CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND
QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING
CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE
REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING
DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE
ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL
STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE
ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE
EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING
SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND
PROVIDING EFFECTIVE DATES, ~~AND~~ AND AN APPLICABILITY DATE, ~~AND A TERMINATION DATE.~~"

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of national accrediting organizations.

1 In order to promote uniformity of standards applicable to all managed care plans, state quality
 2 assurance standards for small managed care plans must consist of standards that are ~~at least the equivalent~~
 3 ~~of health plan employer data and information standards. Any other standards adopted must be~~ appropriate
 4 for quality assurance in Montana.

5 The department ~~AND SUBSEQUENTLY THE BOARD OF NETWORK ADEQUACY AND QUALITY~~
 6 ~~ASSURANCE~~ may refer reports of noncompliance by a health carrier to the commissioner for corrective
 7 action. Under the department's rulemaking authority, the department shall specify network adequacy and
 8 quality assurance review processes.

9 [Section 19] designates the department of public health and human services as the place for
 10 insurance carriers to file documents related to managed care provider network adequacy and quality
 11 assurance. The department shall adopt rules establishing procedures for filing these documents and shall
 12 adopt rules specifying processes for amending or withdrawing documents already filed that relate to
 13 network adequacy and quality assurance.

14
 15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

16
 17 **Section 1.** Section 33-22-1703, MCA, is amended to read:

18 **"33-22-1703. Definitions.** As used in this part, the following definitions apply:

19 (1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient
 20 severity, including severe pain, that the absence of immediate medical attention could reasonably be
 21 expected to result in any of the following:

22 (a) the covered person's health would be in serious jeopardy;

23 (b) the covered person's bodily functions would be seriously impaired; or

24 (c) a bodily organ or part would be seriously damaged.

25 (2) "Emergency services" means ~~services provided after suffering an accidental bodily injury or the~~
 26 ~~sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including~~
 27 ~~severe pain) that without immediate medical attention the subscriber or insured could reasonably expect~~
 28 ~~that:~~

29 ~~(a) the subscriber's or insured's health would be in serious jeopardy;~~

30 ~~(b) the subscriber's or insured's bodily functions would be seriously impaired; or~~

1 ~~(c) a bodily organ or part would be seriously damaged, health care items or services furnished or~~
2 ~~required to evaluate and treat an emergency medical condition.~~

3 ~~(2)(3)~~ "Health benefit plan" means the health insurance policy or subscriber arrangement between
4 the insured or subscriber and the health care insurer that defines the covered services and benefit levels
5 available.

6 ~~(3)(4)~~ "Health care insurer" means:

7 (a) an insurer that provides disability insurance as defined in 33-1-207;

8 (b) a health service corporation as defined in 33-30-101;

9 ~~(c) a health maintenance organization as defined in 33-31-102;~~

10 ~~(d)~~ a fraternal benefit society as described in 33-7-105; or

11 ~~(e)(d)~~ any other entity regulated by the commissioner that provides health coverage except a health
12 maintenance organization.

13 ~~(4)(5)~~ "Health care services" means health care services or products rendered or sold by a provider
14 within the scope of the provider's license or legal authorization or services provided under Title 33, chapter
15 22, part 7.

16 ~~(5)(6)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services
17 under a policy or subscriber contract issued or administered by an insurer.

18 ~~(6)(7)~~ "Preferred provider" means a provider or group of providers who have contracted to provide
19 specified health care services.

20 ~~(7)(8)~~ "Preferred provider agreement" means a contract between or on behalf of a health care
21 insurer and a preferred provider.

22 ~~(8)(9)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care
23 services or services covered within Title 33, chapter 22, part 7.

24 ~~(9)(10)~~ "Subscriber" means a certificate holder or other person on whose behalf the health care
25 insurer is providing or paying for health care coverage."

26
27 **Section 2.** Section 33-22-1707, MCA, is amended to read:

28 **"33-22-1707. Rules.** The commissioner ~~shall promulgate~~ may adopt rules necessary to implement
29 the provisions of this part."
30

1 **Section 3.** Section 33-31-102, MCA, is amended to read:

2 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the
3 following definitions apply:

4 (1) "Basic health care services" means:

5 (a) consultative, diagnostic, therapeutic, and referral services by a provider;

6 (b) inpatient hospital and provider care;

7 (c) outpatient medical services;

8 (d) medical treatment and referral services;

9 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant
10 to 33-31-301(3)(e);

11 (f) care and treatment of mental illness, alcoholism, and drug addiction;

12 (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;

13 (h) preventive health services, including:

14 (i) immunizations;

15 (ii) well-child care from birth;

16 (iii) periodic health evaluations for adults;

17 (iv) voluntary family planning services;

18 (v) infertility services; and

19 (vi) children's eye and ear examinations conducted to determine the need for vision and hearing
20 correction;

21 (i) minimum mammography examination, as defined in 33-22-132; and

22 (j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under
23 the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels
24 of phenylalanine and adequate nutritional status.

25 (2) "Commissioner" means the commissioner of insurance of the state of Montana.

26 (3) "Enrollee" means a person:

27 (a) who enrolls in or contracts with a health maintenance organization;

28 (b) on whose behalf a contract is made with a health maintenance organization to receive health
29 care services; or

30 (c) on whose behalf the health maintenance organization contracts to receive health care services.

1 (4) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee
2 setting forth the coverage to which the enrollee is entitled.

3 (5) "Health care services" means:

4 (a) the services included in furnishing medical or dental care to a person;

5 (b) the services included in hospitalizing a person;

6 (c) the services incident to furnishing medical or dental care or hospitalization; or

7 (d) the services included in furnishing to a person other services for the purpose of preventing,
8 alleviating, curing, or healing illness, injury, or physical disability.

9 (6) "Health care services agreement" means an agreement for health care services between a
10 health maintenance organization and an enrollee.

11 (7) "Health maintenance organization" means a person who provides or arranges for basic health
12 care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees
13 or through contractual or other arrangements with a provider or a group of providers. This subsection does
14 not limit methods of provider payments made by health maintenance organizations. THIS TERM APPLIES
15 TO PROVIDER SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES
16 DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING
17 COOPERATIVES.

18 (8) "Insurance producer" means an individual, partnership, or corporation appointed or authorized
19 by a health maintenance organization to solicit applications for health care services agreements on its
20 behalf.

21 (9) "Person" means:

22 (a) an individual;

23 (b) a group of individuals;

24 (c) an insurer, as defined in 33-1-201;

25 (d) a health service corporation, as defined in 33-30-101;

26 (e) a corporation, partnership, facility, association, or trust; or

27 (f) an institution of a governmental unit of any state licensed by that state to provide health care,
28 including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

29 (10) "Plan" means a health maintenance organization operated by an insurer or health service
30 corporation as an integral part of the corporation and not as a subsidiary.

(11) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or ~~nurse specialist~~ advanced practice registered nurse as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of ~~his~~ the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(12) "PROVIDER SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A PHYSICIAN HOSPITAL ORGANIZATION, A PHYSICIAN SPONSORED NETWORK, A PHYSICIAN GROUP PRACTICE, AND A HOSPITAL PHYSICIAN ORGANIZATION.~~

~~(12)(13)~~(12) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent."

Section 4. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter ~~may not be considered to be~~ is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) ~~The provisions of this~~ This chapter ~~do~~ does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) ~~The provisions of this~~ This section ~~do~~ does not exempt a health maintenance organization from material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance

organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from network adequacy and quality assurance requirements provided under [sections 8 through 29]."

Section 5. Section 33-31-211, MCA, is amended to read:

"33-31-211. Annual ~~statement~~ statements -- revocation for failure to file -- penalty for false swearing. (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file on or before June 1 an audited financial statement.

(2) At the time of filing ~~its~~ the annual statement required by March 1, the health maintenance organization shall pay the commissioner the fee for filing ~~its~~ the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed \$5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he considers~~ considered reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ duties required of the commissioner under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

Section 6. Section 33-31-216, MCA, is amended to read:

"33-31-216. Protection against insolvency. (1) Except as provided in subsections (4) through (7),

1 each authorized health maintenance organization shall deposit with the commissioner cash, securities, or
2 any combination of cash or securities acceptable to the commissioner in the amount set forth in this
3 section.

4 (2) The amount of the deposit for a health maintenance organization during the first year of its
5 operation ~~must be the greater of:~~

6 ~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~

7 ~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~

8 ~~(c) \$100,000 is \$200,000.~~

9 (3) At the beginning of each succeeding year, unless not applicable, the health maintenance
10 organization shall deposit with the commissioner cash, securities, or any combination of cash or securities
11 acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures
12 for that year.

13 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
14 1987, shall make a deposit equal to the greater of:

15 (a) 1% of the preceding 12 months' uncovered expenditures; or

16 (b) ~~\$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987.~~
17 ~~In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its~~
18 ~~estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must~~
19 ~~be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and~~
20 ~~subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual~~
21 ~~uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably~~
22 ~~reflect the preceding year's operating experience and delivery arrangements.~~

23 (5) The commissioner may ~~in his discretion~~ waive any of the deposit requirements set forth in
24 subsections (1) through (4) whenever ~~he~~ the commissioner is satisfied that:

25 (a) the health maintenance organization has sufficient net worth and an adequate history of
26 generating net income to ~~assure~~ ensure its financial viability for the next year;

27 (b) the health maintenance organization's performance and obligations are guaranteed by an
28 organization with sufficient net worth and an adequate history of generating net income; or

29 (c) the health maintenance organization's assets or its contracts with insurers, health service
30 corporations, governments, or other organizations are reasonably sufficient to assure the performance of

1 its obligations.

2 (6) When a health maintenance organization achieves a net worth not including land, buildings, and
3 equipment of at least \$1 million or achieves a net worth including organization-related land, buildings, and
4 equipment of at least \$5 million the annual deposit requirement under subsection (3) does not apply. The
5 annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the
6 total amount of the accumulated deposit is greater than the capital requirement for the formation or
7 admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing
8 organization that has been in operation for at least 5 years and has a net worth not including land,
9 buildings, and equipment of at least \$1 million or that has been in operation for at least 10 years and has
10 a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual
11 deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring
12 more than one health maintenance organization, however, the net worth requirement is increased by a
13 multiple equal to the number of ~~each~~ those health maintenance organizations. This requirement to maintain
14 a deposit in excess of the deposit required of a disability insurer does not apply during any time that the
15 guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at
16 least equal to the capital and surplus requirements for a disability insurer.

17 (7) All income from deposits belongs to the depositing health maintenance organization and must
18 be paid to it as it becomes available. A health maintenance organization that has made a securities deposit
19 may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any
20 combination of cash or securities of equal amount and value. A health maintenance organization may not
21 substitute securities without prior approval by the commissioner.

22 (8) In any year in which an annual deposit is not required of a health maintenance organization,
23 at the health maintenance organization's request, the commissioner shall reduce the previously accumulated
24 deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows the health
25 maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth
26 no longer supports a reduction of its required deposit, the health maintenance organization shall immediately
27 redeposit \$100,000 for each \$250,000 of reduction in net worth, ~~except that its~~. However, the health
28 maintenance organization's total deposit may not be required to exceed the maximum required under this
29 section.

30 (9) Unless it is operated by an insurer or a health service corporation as a plan, each health

1 maintenance organization ~~shall~~ must have a minimum capital of at least \$200,000 in addition to any deposit
2 requirements under this section. The capital account must be in excess of any accrued liabilities and be in
3 the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

4 (10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

5 (a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

6 (b) enrollees will be entitled to similar alternate insurance coverage that does not contain any
7 medical underwriting or preexisting limitation requirements."

8
9 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
10 organization may not increase a premium for an individual's or an individual's group health care services
11 agreement more frequently than once during a 12-month period unless failure to increase the premium more
12 frequently than once during the 12-month period would:

13 (a) place the health maintenance organization in violation of the laws of this state; or

14 (b) cause the financial impairment of the health maintenance organization to the extent that further
15 transaction of insurance by the health maintenance organization would injure or be hazardous to its
16 enrollees or to the public.

17 (2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, by
18 a court decision, by a state rule, or by a federal regulation.

19
20 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
21 Plan Network Adequacy and Quality Assurance Act".

22
23 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

24 (1) establish standards for the creation and maintenance of networks by health carriers offering
25 managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered
26 under a managed care plan by establishing requirements for written agreements between health carriers
27 offering managed care plans and participating providers regarding the standards, terms, and provisions
28 under which the participating provider will provide services to covered persons;

29 (2) provide for the implementation of state network adequacy and quality assurance standards in
30 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for

- 1 detecting and reporting violations of those standards to the commissioner;
- 2 (3) establish minimum criteria for the quality assessment activities of a health carrier issuing a
- 3 closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted
- 4 by rule;
- 5 (4) enable health carriers to evaluate, maintain, and improve the quality of health care services
- 6 provided to covered persons; and
- 7 (5) provide a streamlined and simplified process by which managed care network adequacy and
- 8 quality assurance programs may be monitored for compliance THROUGH COORDINATED EFFORTS OF THE
- 9 COMMISSIONER AND THE DEPARTMENT ~~(AND THE BOARD)~~. It is not the purpose or intent of [sections
- 10 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
- 11 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
- 12 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

13

14 **NEW SECTION.** **Section 10. Definitions.** As used in [sections 8 through 29], the following

15 definitions apply:

- 16 (1) "Closed plan" means a managed care plan that requires covered persons to use only
- 17 participating providers under the terms of the managed care plan.
- 18 (2) "Combination plan" means an open plan with a closed component.
- 19 (3) "Covered benefits" means those health care services to which a covered person is entitled
- 20 under the terms of a health benefit plan.
- 21 (4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating
- 22 in a health benefit plan.
- 23 (5) "Department" means the department of public health and human services established in
- 24 2-15-2201.
- 25 (6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient
- 26 severity, including severe pain, that the absence of immediate medical attention could reasonably be
- 27 expected to result in any of the following:
- 28 (a) the covered person's health would be in serious jeopardy;
- 29 (b) the covered person's bodily functions would be seriously impaired; or
- 30 (c) a bodily organ or part would be seriously damaged.

(7) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(10) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

(11) "Health care provider" or "provider" means a health care professional or a facility.

(12) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(13) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

(14) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

(15) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services, MEDICINES, or supplies that are necessary and appropriate for the DIAGNOSIS OR treatment of a covered person's ~~emergency~~ ILLNESS, INJURY, OR medical condition ~~or for the preventive care of a covered person~~ according to accepted standards of medical practice AND THAT ARE NOT PROVIDED ONLY AS A CONVENIENCE.

(17) "Network" means the group of participating providers that provides health care services to

1 a managed care plan.

2 (18) "Open plan" means a managed care plan other than a closed plan that provides incentives,
3 including financial incentives, for covered persons to use participating providers under the terms of the
4 managed care plan.

5 (19) "Participating provider" means a provider who, under a contract with a health carrier or with
6 the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services
7 to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or
8 deductibles, directly or indirectly from the health carrier.

9 (20) "Primary care professional" means a participating health care professional designated by the
10 health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and
11 who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision
12 of health care services rendered to the covered person.

13 (21) "Quality assessment" means the measurement and evaluation of the quality and outcomes
14 of medical care provided to individuals, groups, or populations.

15 (22) "Quality assurance" means quality assessment and quality improvement.

16 (23) "Quality improvement" means an effort to improve the processes and outcomes related to the
17 provision of health care services within a health plan.

18

19 **NEW SECTION.** **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
20 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
21 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
22 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
23 medicaid recipients.

24

25 **NEW SECTION.** **Section 12. Department -- general powers and duties -- rulemaking.** (1) The
26 department shall:

27 (a) adopt rules pursuant to the Montana Administrative Procedure Act establishing minimum state
28 standards for network adequacy and quality assurance and procedures for ensuring compliance with those
29 standards; and

30 (b) recommend action to the commissioner ~~FOR TO THE BOARD~~ against a health carrier whose

1 managed care plan does not comply with standards for network adequacy and quality assurance adopted
2 by the department.

3 (2) Quality assurance standards adopted by the department must consist of some but not all of the
4 health plan employer data and information standards. The department shall select and adopt only standards
5 appropriate for quality assurance in Montana.

6 (3) The state may contract, through a competitive bidding process, for the development of network
7 adequacy and quality assurance standards.

8
9 **NEW SECTION. Section 13. Network adequacy -- standards -- access plan required.** (1) A health
10 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
11 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
12 Sufficiency in number and type of provider is determined in accordance with the requirements of this
13 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
14 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
15 may include but are not limited to:

16 (a) a ratio of specialty care providers to covered persons;

17 (b) a ratio of primary care providers to covered persons;

18 (c) geographic accessibility;

19 (d) waiting times for appointments with participating providers;

20 (e) hours of operation; or

21 (f) the volume of technological and specialty services available to serve the needs of covered
22 persons requiring technologically advanced or specialty care.

23 (2) Whenever a health carrier has an insufficient number or type of participating providers to
24 provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered
25 benefit at no greater cost to the covered person than if the covered benefit were obtained from participating
26 providers or shall make other arrangements acceptable to the department.

27 (3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable
28 proximity of participating providers to the businesses or personal residences of covered persons. In
29 determining whether a health carrier has complied with this requirement, consideration must be given to
30 the relative availability of health care providers in the service area under consideration.

~~(4) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability, and legal authority of its providers to furnish all covered benefits to covered persons.~~

~~(5)~~(4) A health carrier offering a managed care plan in this state on October 1, 1998, shall file with the department on October 1, 1998, an access plan complying with subsection ~~(7)~~ (6) and the rules of the department. A health carrier offering a managed care plan in this state for the first time after October 1, 1998, shall file with the department an access plan meeting the requirements of subsection ~~(7)~~ (6) and the rules of the department before offering the managed care plan. A plan must be filed with the department in a manner and form complying with the rules of the department. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

~~(6)~~(5) A health carrier may request the department to designate parts of its access plan as proprietary or competitive information, and when designated, that part may not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. A health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the plan upon request.

~~(7)~~(6) An access plan for each managed care plan offered in this state must describe or contain at least the following:

- (a) a listing of the names and specialties of the health carrier's participating providers;
- (b) the health carrier's procedures for making referrals within and outside its network;
- (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in the managed care plan;
- (d) the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
- (e) the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
- (f) the health carrier's method of informing covered persons of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;
- (g) the health carrier's system for ensuring the coordination and continuity of care for covered

persons referred to specialty physicians and for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) the health carrier's process for enabling covered persons to change primary care professionals;

(i) the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and a participating provider or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and be transferred to other providers in a timely manner.

(j) any other information required by the department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

(7) THE DEPARTMENT SHALL ENSURE TIMELY AND EXPEDITED REVIEW AND APPROVAL OF THE ACCESS PLAN AND OTHER REQUIREMENTS IN THIS SECTION.

NEW SECTION. **Section 14. Provider responsibility for care -- contracts -- prohibited collection practices.** ~~(1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, by which a participating provider will be notified on an ongoing basis of the covered health care services for which the participating provider is responsible, including any limitations or conditions on those health care services.~~

~~(2)~~(1) A contract between a health carrier and a participating provider must set forth a hold harmless provision specifying protection for covered persons. This requirement is met by including in a contract a provision substantially the same as the following:

"The provider agrees that the provider may not for any reason, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a covered person or a person other than the health carrier or intermediary acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person. This agreement does not prohibit a provider, except a health care professional who is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to

that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person if the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available for obtaining payment for services from the health carrier."

~~(3)(2)~~ A contract between a health carrier and a participating provider must state that if a health carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered persons will continue through the end of the period for which a premium has been paid to the health carrier on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an ACUTE CARE inpatient facility on the date of insolvency or other cessation of operations must be continued by a provider until the confinement in an inpatient facility is no longer medically necessary.

~~(4)(3)~~ The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2) must be construed in favor of the covered person, survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and supersede an oral or written contrary agreement between a participating provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by subsections ~~(2) and (3)~~ (1) AND (2).

~~(5)(4)~~ A participating provider may not collect or attempt to collect from a covered person money owed to the provider by the health carrier.

NEW SECTION. Section 15. Selection of providers -- professional credentials standards. (1) A health carrier shall adopt standards for selecting participating providers who are primary care professionals and for each health care professional specialty within the health carrier's network. The health carrier shall use the standards to select health care professionals, the health carrier's intermediaries, and any provider network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow the health carrier to:

(a) avoid high-risk populations by excluding a provider because the provider is located in a geographic area that contains populations or providers presenting a risk of higher than average claims, losses, or use of health care services; or

1 (b) exclude a provider because the provider treats or specializes in treating populations presenting
2 a risk of higher than average claims, losses, or use of health care services.

3 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
4 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
5 through 21] and the rules implementing [sections 13 through 21].

6 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
7 with which the health carrier or its intermediary contract to employ specific providers or types of providers
8 who may meet their selection criteria or to contract with or retain more providers or types of providers than
9 are necessary to maintain an adequate network.

10 (4) A health carrier may use criteria established in accordance with the provisions of this section
11 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
12 carrier shall make its selection standards for participating providers available for review by the department
13 and by each health care professional who is subject to the selection standards.

14
15 **NEW SECTION. Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering
16 a managed care plan shall notify, in writing, prospective participating providers of the participating
17 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
18 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
19 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
20 requirements.

21 (2) A health carrier may not offer an inducement under a managed care plan to a participating
22 provider to provide less than medically necessary services to a covered person.

23 (3) A health carrier may not prohibit a participating provider from discussing a treatment option
24 with a covered person or from advocating on behalf of a covered person within the utilization review or
25 grievance processes established by the health carrier or a person contracting with the health carrier.

26 (4) A health carrier shall require a participating provider to make health records available to
27 appropriate state and federal authorities, in accordance with the applicable state and federal laws related
28 to the confidentiality of medical or health records, when the authorities are involved in assessing the quality
29 of care or investigating a grievance or complaint of a covered person.

30 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each

1 other before terminating the contract between them without cause. The health carrier shall make a good
2 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
3 notice of termination from or to a participating provider, to all covered persons who are patients seen on
4 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
5 termination is for cause or without cause. If a contract termination involves a primary care professional,
6 all covered persons who are patients of that primary care professional must be notified.

7 (6) A health carrier shall ensure that a participating provider furnishes covered benefits to all
8 covered persons without regard to the covered person's enrollment in the plan as a private purchaser or
9 as a participant in a publicly financed program of health care services. This requirement does not apply to
10 circumstances in which the participating provider should not render services because of the participating
11 provider's lack of training, experience, or skill or because of a restriction on the participating provider's
12 license.

13 (7) A health carrier shall notify the participating providers of their obligation, if any, to collect
14 applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of
15 coverage or of the participating providers' obligations, if any, to notify covered persons of the covered
16 persons' personal financial obligations for noncovered benefits.

17 (8) A health carrier may not penalize a participating provider because the participating provider,
18 in good faith, reports to state or federal authorities an act or practice by the health carrier that may
19 adversely affect patient health or welfare.

20 (9) A health carrier shall establish a mechanism by which a participating provider may determine
21 in a timely manner whether or not a person is covered by the health carrier.

22 (10) A health carrier shall establish procedures for resolution of administrative, payment, or other
23 disputes between the health carrier and participating providers.

24 (11) A contract between a health carrier and a participating provider may not contain definitions
25 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
26 [sections 8 through 29].

27 (12) A contract between a health carrier and a participating provider shall set forth all of the
28 responsibilities and obligations of the provider either in the contract or documents referenced in the
29 contract. A health carrier shall make its best effort to furnish copies of any reference documents, if
30 requested by a participating provider, prior to execution of the contract.

1 **NEW SECTION.** **Section 17. Emergency services.** (1) A health carrier offering a managed care plan
2 shall provide or pay for emergency services screening and emergency services and may not require prior
3 authorization for either of those services. If an emergency services screening determines that emergency
4 services or emergency services of a particular type are unnecessary for a covered person, emergency
5 services or emergency services of the type determined unnecessary by the screening need not be covered
6 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
7 determines that emergency services or emergency services of a particular type are necessary, those
8 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
9 carrier, acting through a participating provider or other authorized representative, has authorized the
10 provision of emergency services.

11 (2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork
12 provider within the service area of a managed care plan and may not require prior authorization of those
13 services if use of a participating provider would result in a delay that would worsen the medical condition
14 of the covered person or if a provision of federal, state, or local law requires the use of a specific provider.

15 (3) If a participating provider or other authorized representative of a health carrier authorizes
16 emergency services, the health carrier may not subsequently retract its authorization after the emergency
17 services have been provided or reduce payment for an item or health care services furnished in reliance on
18 approval unless the approval was based on a material misrepresentation about the covered person's medical
19 condition made by the provider of emergency services.

20 (4) Coverage of emergency services is subject to applicable coinsurance, copayments, and
21 deductibles.

22 (5) For postevaluation or poststabilization services required immediately after receipt of emergency
23 services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a
24 week, to facilitate review.

25
26 **NEW SECTION.** **Section 18. Use of intermediaries -- responsibilities of health carriers,**
27 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
28 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which
29 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

30 (2) A health carrier may determine whether a subcontracted provider participates in the provider's

own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) A health carrier shall maintain copies of all intermediary health care subcontracts at the health carrier's principal place of business in this state or ensure that the health carrier has access to all intermediary subcontracts, including the right to make copies of the contracts, upon 20 days' prior written notice from the health carrier.

(4) If required in a contract or otherwise by a health carrier, an intermediary shall transmit utilization documentation and claims-paid documentation to the health carrier. The health carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons. This duty may not be delegated to an intermediary by a health carrier.

(5) If required in a contract or otherwise by a health carrier, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and preserve them for 5 years in a manner that facilitates regulatory review.

(6) An intermediary shall allow the COMMISSIONER AND THE department access to the intermediary's books, records, claim information, billing information, and other documentation of services provided to covered persons that are required by any of those entities to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

(7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to the health carrier of the provisions of a participating provider's contract addressing the participating provider's obligation to furnish covered benefits.

NEW SECTION. **Section 19. Contract filing requirements -- material changes -- state access to contracts.** (1) On October 1, 1998, a health carrier offering a managed care plan shall file with the department sample contract forms proposed for use with its participating providers and intermediaries.

(2) A health carrier shall file with the department a material change to a contract. The change must be filed with the department at least 60 days before use of the proposed change. A change in a participating provider payment rate, coinsurance, copayment, or deductible or other plan benefit is not considered a material change for the purpose of this subsection.

(3) A health carrier shall maintain participating provider and intermediary contracts at its principal

1 place of business in this state, or the health carrier must have access to all contracts and provide copies
2 to the department upon 20 days' prior written notice from the department.

3
4 **NEW SECTION. Section 20. General contracting requirements.** (1) The execution of a contract
5 for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty
6 to provide health care services to a person with whom the health carrier has contracted and does not
7 relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules
8 implementing [sections 8 through 29].

9 (2) All contracts by a health carrier for the provision of health care services by a managed care plan
10 must be in writing and are subject to review by the department and the commissioner.

11
12 **NEW SECTION. Section 21. Contract compliance dates.** (1) A contract between a health carrier
13 and a participating provider or intermediary in effect on October 1, 1997, must comply with [sections 13
14 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department may
15 extend the April 1 date for an additional period of up to 6 months if the health carrier demonstrates good
16 cause for an extension.

17 (2) A contract between a health carrier and a participating provider or intermediary issued or put
18 into effect on or after April 1, 1998, must comply with [sections 13 through 21] and the rules implementing
19 [sections 13 through 21] on the day that it is issued or put into effect.

20 (3) A contract between a health carrier and a participating provider or intermediary not described
21 in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections
22 13 through 21] by April 1, 1999.

23
24 **NEW SECTION. Section 22. Department rules.** The department shall adopt rules to implement
25 [sections 13 through 21].

26
27 **NEW SECTION. Section 23. Quality assurance -- national accreditation.** (1) A health carrier
28 whose managed care plan has been accredited by a nationally recognized accrediting organization shall
29 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
30 organization to the department.

(2) If the department finds that the standards of a nationally recognized accrediting organization meet or exceed state standards and that the health carrier has been accredited by the nationally recognized accrediting organization, the department shall approve the quality assurance standards of the health carrier.

(3) The department shall maintain a list of accrediting organizations whose standards have been determined by the department to meet or exceed state quality assurance standards.

(4) [Section 24] does not apply to a health carrier's managed care plan if the health carrier maintains current accreditation by a nationally recognized accrediting organization whose standards meet or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

(5) This section does not prevent the department from monitoring a health carrier's compliance with [sections 23 through 27].

NEW SECTION. Section 24. Standards for health carrier quality assessment programs. A health carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure systems sufficient to accurately measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this requirement, a health carrier shall:

(1) establish and use a system designed to assess the quality of health care provided to covered persons and appropriate to the types of plans offered by the health carrier. The system must include systematic collection, analysis, and reporting of relevant data.

(2) communicate in a timely fashion its findings concerning the quality of health care to regulatory agencies, providers, and consumers as provided in [section 26];

(3) report to the appropriate professional or occupational licensing board provided in Title 37 any persistent pattern of problematic care provided by a participating provider that is sufficient to cause the health carrier to terminate or suspend a contractual arrangement with the participating provider; and

(4) file a written description of the quality assessment program and any subsequent material changes with the department in a format that must be prescribed by rules of the department. The description must include a signed certification by a corporate officer of the health carrier that the health carrier's quality assessment program meets the requirements of [sections 23 through 27].

NEW SECTION. Section 25. Standards for health carrier quality improvement programs. A health

1 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
2 adopt and use systems and methods necessary to improve the quality of health care provided in the health
3 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
4 by this section. To comply with this requirement, a health carrier subject to this section shall:

5 (1) establish an internal system capable of identifying opportunities to improve care;

6 (2) use the findings generated by the system required by subsection (1) to work on a continuing
7 basis with participating providers and other staff within the closed plan or closed component to improve
8 the health care delivered to covered persons;

9 (3) adopt and use a program for measuring, assessing and improving the outcomes of health care
10 as identified in the health carrier's quality improvement program plan. This quality improvement program
11 plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23
12 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program
13 plan within 30 days of implementation of the change. The quality improvement program plan must:

14 (a) implement improvement strategies in response to quality assessment findings that indicate
15 improvement is needed; and

16 (b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to
17 subsection (3)(a).

18
19 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
20 a closed plan or a combination plan shall document and communicate information, as required in this
21 section, about its quality assurance program. The health carrier shall:

22 (a) include a summary of its quality assurance program in marketing materials;

23 (b) include a description of its quality assurance program and a statement of patient rights and
24 responsibilities with respect to that program in the certificate of coverage or handbook provided to newly
25 enrolled covered persons; and

26 (c) make available annually to providers and covered persons a report containing findings from its
27 quality assurance program and information about its progress in meeting internal goals and external
28 standards, when available.

29 (2) A health carrier shall certify to the department annually that its quality assurance program and
30 the materials provided to providers and consumers in accordance with subsection (1) meet the requirements

of [sections 23 through 27].

(3) A health carrier shall make available, upon request and payment of a reasonable fee, the materials certified pursuant to subsection (2), except for the materials subject to the confidentiality requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier shall retain all certified materials for at least 3 years from the date that the material was certified or until the material has been examined as part of a market conduct examination, whichever is later.

NEW SECTION. Section 27. Confidentiality of health care and quality assurance records -- disclosure. (1) Except as provided in subsection (2), the following information held by a health carrier offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a person:

(a) information pertaining to the diagnosis, treatment, or health of a covered person, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form;

(b) information considered by a quality assurance program and the records of its actions, including testimony of a member of a quality committee, of an officer, director, or other member of a health carrier or its staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment, quality improvement, or quality assurance activities, or of any person assisting or furnishing information to the quality committee.

(2) The information specified in subsection (1) may be disclosed:

(a) as allowed by Title 33, chapter 19;

(b) as required in proceedings before the commissioner, a professional or occupational licensing board provided in Title 37, or the department pursuant to Title 50, chapter 5, part 2;

(c) in an appeal, if an appeal is permitted, from a quality committee's findings or recommendations;
or

(d) as otherwise required by law or court order, including a judicial or administrative subpoena.

(3) Information specified in subsection (1) identifying:

(a) the provider may also be disclosed upon a written, dated, and signed approval of the provider if the information does not identify the covered person;

(b) the covered person may also be disclosed upon a written, dated, and signed approval of the

covered person or of the parent or guardian of a covered person if the covered person is a minor and if the information does not identify the provider;

(c) neither the provider nor the covered person may also be disclosed upon request for use for statistical purposes only.

NEW SECTION. Section 28. Enforcement. (1) If the department ~~[OR THE BOARD]~~ determines that a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the department ~~[OR THE BOARD]~~ may recommend corrective action to the health carrier.

(2) ~~The AT THE RECOMMENDATION OF THE DEPARTMENT [OR THE BOARD] THE~~ commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the department ~~[OR THE BOARD]~~;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a reasonable period of time;

(c) the department ~~[OR THE BOARD]~~ demonstrates to the commissioner that a health carrier does not comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 8 through 29] or the rules implementing [sections 8 through 29].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

(a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's application for a certificate of authority; or

(b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part 3.

NEW SECTION. Section 29. Jurisdiction over contract actions. The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

~~**NEW SECTION. SECTION 30. DEFINITIONS. AS USED IN [SECTIONS 8 THROUGH 29], THE**~~

FOLLOWING DEFINITIONS APPLY:

(1) "BOARD" MEANS THE BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE PROVIDED FOR IN [SECTION 31].

(2) "CLOSED PLAN" MEANS A MANAGED CARE PLAN THAT REQUIRES COVERED PERSONS TO USE ONLY PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.

(3) "COMBINATION PLAN" MEANS AN OPEN PLAN WITH A CLOSED COMPONENT.

(4) "COVERED BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH A COVERED PERSON IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN.

(5) "COVERED PERSON" MEANS A POLICYHOLDER, SUBSCRIBER, OR ENROLLEE OR OTHER INDIVIDUAL PARTICIPATING IN A HEALTH BENEFIT PLAN.

(6) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ESTABLISHED IN 2-15-2201.

(7) "EMERGENCY MEDICAL CONDITION" MEANS A CONDITION MANIFESTING ITSELF BY SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN ANY OF THE FOLLOWING:

(A) THE COVERED PERSON'S HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) THE COVERED PERSON'S BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(8) "EMERGENCY SERVICES" MEANS HEALTH CARE ITEMS AND SERVICES FURNISHED OR REQUIRED TO EVALUATE AND TREAT AN EMERGENCY MEDICAL CONDITION.

(9) "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH CARE SETTING, INCLUDING BUT NOT LIMITED TO A HOSPITAL, MEDICAL ASSISTANCE FACILITY, AS DEFINED IN 50-5-101, OR OTHER LICENSED INPATIENT CENTER, AN AMBULATORY SURGICAL OR TREATMENT CENTER, A SKILLED NURSING CENTER, A RESIDENTIAL TREATMENT CENTER, A DIAGNOSTIC, LABORATORY, OR IMAGING CENTER, OR A REHABILITATION OR OTHER THERAPEUTIC HEALTH SETTING.

(10) "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT ENTERED INTO, OFFERED, OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

(11) "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN OR OTHER HEALTH CARE

~~PRACTITIONER LICENSED, ACCREDITED, OR CERTIFIED PURSUANT TO THE LAWS OF THIS STATE TO
PERFORM SPECIFIED HEALTH CARE SERVICES CONSISTENT WITH STATE LAW.~~

~~(12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR
A FACILITY.~~

~~(13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION,
TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.~~

~~(14) "HEALTH CARRIER" MEANS AN ENTITY SUBJECT TO THE INSURANCE LAWS AND RULES
OF THIS STATE THAT CONTRACTS, OFFERS TO CONTRACT, OR ENTERS INTO AN AGREEMENT TO
PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE
SERVICES, INCLUDING A DISABILITY INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH
SERVICE CORPORATION OR ANOTHER ENTITY PROVIDING A HEALTH BENEFIT PLAN.~~

~~(15) "INTERMEDIARY" MEANS A PERSON AUTHORIZED TO NEGOTIATE, EXECUTE, AND BE A
PARTY TO A CONTRACT BETWEEN A HEALTH CARRIER AND A PROVIDER OR BETWEEN A HEALTH
CARRIER AND A NETWORK.~~

~~(16) "MANAGED CARE PLAN" MEANS A HEALTH BENEFIT PLAN THAT EITHER REQUIRES OR
CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR A COVERED PERSON TO USE HEALTH
CARE PROVIDERS MANAGED, OWNED, UNDER CONTRACT WITH, OR EMPLOYED BY A HEALTH
CARRIER, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS
OPERATED IN A FEE-FOR-SERVICE INDEMNITY ENVIRONMENT.~~

~~(17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND
APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR
FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF
MEDICAL PRACTICE.~~

~~(18) "NETWORK" MEANS THE GROUP OF PARTICIPATING PROVIDERS THAT PROVIDES HEALTH
CARE SERVICES TO A MANAGED CARE PLAN.~~

~~(19) "OPEN PLAN" MEANS A MANAGED CARE PLAN OTHER THAN A CLOSED PLAN THAT
PROVIDES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR COVERED PERSONS TO USE
PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

~~(20) "PARTICIPATING PROVIDER" MEANS A PROVIDER WHO, UNDER A CONTRACT WITH A
HEALTH CARRIER OR WITH THE HEALTH CARRIER'S CONTRACTOR, SUBCONTRACTOR, OR~~

~~INTERMEDIARY, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED PERSONS WITH AN EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE, COPAYMENTS, OR DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE HEALTH CARRIER.~~

~~(21) "PRIMARY CARE PROFESSIONAL" MEANS A PARTICIPATING HEALTH CARE PROFESSIONAL DESIGNATED BY THE HEALTH CARRIER TO SUPERVISE, COORDINATE, OR PROVIDE INITIAL CARE OR CONTINUING CARE TO A COVERED PERSON AND WHO MAY BE REQUIRED BY THE HEALTH CARRIER TO INITIATE A REFERRAL FOR SPECIALTY CARE AND TO MAINTAIN SUPERVISION OF HEALTH CARE SERVICES RENDERED TO THE COVERED PERSON.~~

~~(22) "QUALITY ASSESSMENT" MEANS THE MEASUREMENT AND EVALUATION OF THE QUALITY AND OUTCOMES OF MEDICAL CARE PROVIDED TO INDIVIDUALS, GROUPS, OR POPULATIONS.~~

~~(23) "QUALITY ASSURANCE" MEANS QUALITY ASSESSMENT AND QUALITY IMPROVEMENT.~~

~~(24) "QUALITY IMPROVEMENT" MEANS AN EFFORT TO IMPROVE THE PROCESSES AND OUTCOMES RELATED TO THE PROVISION OF HEALTH CARE SERVICES WITHIN A HEALTH PLAN.~~

~~NEW SECTION. SECTION 31. BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE.~~

~~(1) THERE IS A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE. THE BOARD IS COMPOSED OF A MEDICAL DIRECTOR, THE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, PROVIDED FOR IN 2-15-2201, AND THE COMMISSIONER OF INSURANCE, PROVIDED FOR IN 2-15-1903.~~

~~(2) THE MEDICAL DIRECTOR IS APPOINTED BY THE GOVERNOR AND MUST BE LICENSED AS A PHYSICIAN BY THE STATE OF MONTANA. THE MEDICAL DIRECTOR MUST BE A SPECIALIST IN EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

~~(3) THE GENERAL POWERS AND DUTIES OF THE BOARD ARE PROVIDED IN [SECTION 32].~~

~~(4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT PURSUANT TO 2-15-121.~~

~~NEW SECTION. SECTION 32. BOARD GENERAL POWERS AND DUTIES. THE BOARD SHALL:~~

~~(1) PERIODICALLY REVIEW THE STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS PROVIDED IN [SECTIONS 8 THROUGH 29] AND THE RULES IMPLEMENTING [SECTIONS 8~~

1 ~~THROUGH 29];~~

2 ~~(2) RECOMMEND CORRECTIVE ACTION NECESSARY FOR THE HEALTH CARRIER TO ACHIEVE~~
3 ~~COMPLIANCE WITH STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS; AND~~

4 ~~(3) RECOMMEND ACTION TO THE COMMISSIONER AGAINST A HEALTH CARRIER WHOSE~~
5 ~~MANAGED CARE PLAN DOES NOT COMPLY WITH STANDARDS FOR NETWORK ADEQUACY AND~~
6 ~~QUALITY ASSURANCE ADOPTED BY THE BOARD.~~

7
8 **NEW SECTION. Section 30. Codification instruction.** (1) [Section 7] is intended to be codified as
9 an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

10 (2) [Sections 8 through ~~29-32~~ 29] are intended to be codified as an integral part of Title 33, and
11 the provisions of Title 33 apply to [sections 8 through ~~29-32~~ 29].

12
13 **NEW SECTION. Section 31. Severability.** If a part of [this act] is invalid, all valid parts that are
14 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
15 applications, the part remains in effect in all valid applications that are severable from the invalid
16 applications.

17
18 **NEW SECTION. Section 32. Applicability.** [This act] applies to a health carrier as defined in
19 [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of
20 this section].

21
22 **NEW SECTION. Section 33. Effective dates.** (1) Except as provided in subsections (2) and (3),
23 [this act] is effective January 1, 1998.

24 (2) [Sections 22 and 30 through ~~32, 33 THROUGH 35, AND 37 AND 30 THROUGH 32~~ and this
25 section] are effective on passage and approval.

26 (3) [Sections 23 through 26] are effective October 1, 1999.

27 ~~(4) [SECTIONS 30 THROUGH 32] AND THE LANGUAGE IN BRACKETS IN [SECTIONS 9, 12, AND~~
28 ~~28] ARE EFFECTIVE JULY 1, 2001.~~

29
30 ~~NEW SECTION. SECTION 37. TERMINATION. [SECTION 10] TERMINATES JUNE 30, 2001.~~

-END-

OFFICE OF THE GOVERNOR

STATE OF MONTANA



MARC RACICOT
GOVERNOR

STATE CAPITOL
HELENA, MONTANA 59620-0801

April 21, 1997

The Honorable Gary Aklestad
President of the Senate
State Capitol
Helena MT 59620

The Honorable John Mercer
Speaker of the House
State Capitol
Helena MT 59620

Dear President Aklestad and Speaker Mercer:

In accordance with the power vested in me as Governor by the Constitution and laws of the State of Montana, I hereby return with amendments Senate Bill 365, **"AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE"** for the following reasons.

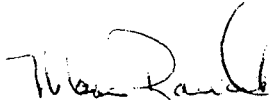
Senate Bill 365 establishes adequate health care networks and quality of managed care. It is an important and visionary bill that will benefit both consumers and managed health care providers in Montana. Applications for health maintenance organizations are pending, and the bill needs to be passed this session.

However, Senate Bill 365 will have a fiscal impact on both the Department of Public

Health and Human Services, as well as the State Auditor's Office. These costs were not funded in House Bill 2, and thus it will be necessary to delay the effective dates of several of the sections of Senate Bill 365.

Senator Benedict, the bill's sponsor, has been informed of the need for these amendments.

Sincerely,

A handwritten signature in dark ink, appearing to read "Marc Racicot", with a stylized flourish at the end.

MARC RACICOT
Governor

GOVERNOR'S AMENDMENTS TO
Senate Bill No. 365
(Reference Copy)
April 21, 1997

Page 15, line 3.
Strike: "1998"
Insert: "1999"
Following: "October 1,"

Page 15, line 4.
Strike: "1998"
Insert: "1999"
Following: "October 1,"

Page 15, line 6.
Strike: "1998"
Insert: "1999"
Following: "October 1,"

Page 21, line 24.
Strike: "1998"
Insert: "1999"
Following: "October 1,"

Page 22, line 13.
Strike: "1997"
Insert: "1999"
Following: "October 1,"

Page 22, line 14.
Strike: "April"
Insert: "October"
Following: "by"

Page 22, line 15.
Strike: "April"
Insert: "October"

GOVERNOR'S AMENDMENTS TO

Senate Bill No. 365

(Reference Copy)

April 21, 1997

Page 22, line 18.

Strike: "April 1, 1998"

Insert: "October 1, 1999"

Following: "after"

Page 22, line 22.

Strike: "April"

Insert: "October"

Following: "by"

Page 22, line 24.

Strike: "shall"

Insert: "may"

Following: "department"

Page 30, Line 24.

Insert: "12,"

Following: "Sections"

Page 30, line 26.

Insert: "13, 15, 18 through 21,"

Following: "Sections"

Strike: "26"

Insert: "29"

SENATE BILL NO. 365

INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD,
MASOLO, BAER, M. TAYLOR, MILLS, ROSE, MAHLUM, MOOD, SPRAGUE, JABS, ESTRADA,
DEPRATU, FOSTER, MCNUTT, KEATING, JENKINS, CRISMORE, GLASER, HERTEL, BURNETT,
THOMAS, SMITH, CRIPPEN, COLE, BOHLINGER, PECK, DENNY, OHS, GRINDE, BOOKOUT-REINICKE,
BARNETT, MARSHALL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE
CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND
QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING
CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE
REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING
DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE
ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL
STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE
ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE
EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING
SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND
PROVIDING EFFECTIVE DATES, ~~AND~~ AND AN APPLICABILITY DATE, ~~AND A TERMINATION DATE.~~"

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of national accrediting organizations.

1 In order to promote uniformity of standards applicable to all managed care plans, state quality
2 assurance standards for small managed care plans must consist of standards that are ~~at least the equivalent~~
3 ~~of health plan employer data and information standards. Any other standards adopted must be appropriate~~
4 for quality assurance in Montana.

5 The department ~~AND SUBSEQUENTLY THE BOARD OF NETWORK ADEQUACY AND QUALITY~~
6 ~~ASSURANCE~~ may refer reports of noncompliance by a health carrier to the commissioner for corrective
7 action. Under the department's rulemaking authority, the department shall specify network adequacy and
8 quality assurance review processes.

9 [Section 19] designates the department of public health and human services as the place for
10 insurance carriers to file documents related to managed care provider network adequacy and quality
11 assurance. The department shall adopt rules establishing procedures for filing these documents and shall
12 adopt rules specifying processes for amending or withdrawing documents already filed that relate to
13 network adequacy and quality assurance.

14
15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

16
17 Section 1. Section 33-22-1703, MCA, is amended to read:

18 "33-22-1703. Definitions. As used in this part, the following definitions apply:

19 (1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient
20 severity, including severe pain, that the absence of immediate medical attention could reasonably be
21 expected to result in any of the following:

22 (a) the covered person's health would be in serious jeopardy;

23 (b) the covered person's bodily functions would be seriously impaired; or

24 (c) a bodily organ or part would be seriously damaged.

25 (2) "Emergency services" means ~~services provided after suffering an accidental bodily injury or the~~
26 ~~sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including~~
27 ~~severe pain) that without immediate medical attention the subscriber or insured could reasonably expect~~
28 ~~that;~~

29 ~~(a) the subscriber's or insured's health would be in serious jeopardy;~~

30 ~~(b) the subscriber's or insured's bodily functions would be seriously impaired; or~~

1 ~~(e) a bodily organ or part would be seriously damaged.~~ health care items or services furnished or
2 required to evaluate and treat an emergency medical condition.

3 ~~(2)(3)~~ "Health benefit plan" means the health insurance policy or subscriber arrangement between
4 the insured or subscriber and the health care insurer that defines the covered services and benefit levels
5 available.

6 ~~(3)(4)~~ "Health care insurer" means:

7 (a) an insurer that provides disability insurance as defined in 33-1-207;

8 (b) a health service corporation as defined in 33-30-101;

9 (c) ~~a health maintenance organization as defined in 33-31-102;~~

10 ~~(d)~~ a fraternal benefit society as described in 33-7-105; or

11 ~~(e)(d)~~ any other entity regulated by the commissioner that provides health coverage except a health
12 maintenance organization.

13 ~~(4)(5)~~ "Health care services" means health care services or products rendered or sold by a provider
14 within the scope of the provider's license or legal authorization or services provided under Title 33, chapter
15 22, part 7.

16 ~~(5)(6)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services
17 under a policy or subscriber contract issued or administered by an insurer.

18 ~~(6)(7)~~ "Preferred provider" means a provider or group of providers who have contracted to provide
19 specified health care services.

20 ~~(7)(8)~~ "Preferred provider agreement" means a contract between or on behalf of a health care
21 insurer and a preferred provider.

22 ~~(8)(9)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care
23 services or services covered within Title 33, chapter 22, part 7.

24 ~~(9)(10)~~ "Subscriber" means a certificate holder or other person on whose behalf the health care
25 insurer is providing or paying for health care coverage."

26
27 **Section 2.** Section 33-22-1707, MCA, is amended to read:

28 **"33-22-1707. Rules.** The commissioner ~~shall promulgate~~ may adopt rules necessary to implement
29 the provisions of this part."
30

1 **Section 3.** Section 33-31-102, MCA, is amended to read:

2 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the
3 following definitions apply:

4 (1) "Basic health care services" means:

5 (a) consultative, diagnostic, therapeutic, and referral services by a provider;

6 (b) inpatient hospital and provider care;

7 (c) outpatient medical services;

8 (d) medical treatment and referral services;

9 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant
10 to 33-31-301(3)(e);

11 (f) care and treatment of mental illness, alcoholism, and drug addiction;

12 (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;

13 (h) preventive health services, including:

14 (i) immunizations;

15 (ii) well-child care from birth;

16 (iii) periodic health evaluations for adults;

17 (iv) voluntary family planning services;

18 (v) infertility services; and

19 (vi) children's eye and ear examinations conducted to determine the need for vision and hearing
20 correction;

21 (i) minimum mammography examination, as defined in 33-22-132; and

22 (j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under
23 the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels
24 of phenylalanine and adequate nutritional status.

25 (2) "Commissioner" means the commissioner of insurance of the state of Montana.

26 (3) "Enrollee" means a person:

27 (a) who enrolls in or contracts with a health maintenance organization;

28 (b) on whose behalf a contract is made with a health maintenance organization to receive health
29 care services; or

30 (c) on whose behalf the health maintenance organization contracts to receive health care services.

1 (4) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee
2 setting forth the coverage to which the enrollee is entitled.

3 (5) "Health care services" means:
4 (a) the services included in furnishing medical or dental care to a person;
5 (b) the services included in hospitalizing a person;
6 (c) the services incident to furnishing medical or dental care or hospitalization; or
7 (d) the services included in furnishing to a person other services for the purpose of preventing,
8 alleviating, curing, or healing illness, injury, or physical disability.

9 (6) "Health care services agreement" means an agreement for health care services between a
10 health maintenance organization and an enrollee.

11 (7) "Health maintenance organization" means a person who provides or arranges for basic health
12 care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees
13 or through contractual or other arrangements with a provider or a group of providers. This subsection does
14 not limit methods of provider payments made by health maintenance organizations. THIS TERM APPLIES
15 TO PROVIDER SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES
16 DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING
17 COOPERATIVES.

18 (8) "Insurance producer" means an individual, partnership, or corporation appointed or authorized
19 by a health maintenance organization to solicit applications for health care services agreements on its
20 behalf.

21 (9) "Person" means:
22 (a) an individual;
23 (b) a group of individuals;
24 (c) an insurer, as defined in 33-1-201;
25 (d) a health service corporation, as defined in 33-30-101;
26 (e) a corporation, partnership, facility, association, or trust; or
27 (f) an institution of a governmental unit of any state licensed by that state to provide health care,
28 including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

29 (10) "Plan" means a health maintenance organization operated by an insurer or health service
30 corporation as an integral part of the corporation and not as a subsidiary.

(11) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or ~~nurse specialist~~ advanced practice registered nurse as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of ~~his~~ the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(12) "PROVIDER SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A PHYSICIAN HOSPITAL ORGANIZATION, A PHYSICIAN SPONSORED NETWORK, A PHYSICIAN GROUP PRACTICE, AND A HOSPITAL PHYSICIAN ORGANIZATION.~~

~~(12)(13)~~(12) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent."

Section 4. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter ~~may not be considered to be~~ is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) ~~The provisions of this~~ This chapter ~~do~~ does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) ~~The provisions of this~~ This section ~~do~~ does not exempt a health maintenance organization from material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance

organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from network adequacy and quality assurance requirements provided under [sections 8 through 29]."

Section 5. Section 33-31-211, MCA, is amended to read:

"33-31-211. ~~Annual statement~~ statements -- revocation for failure to file -- penalty for false swearing. (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file on or before June 1 an audited financial statement.

(2) At the time of filing ~~its~~ the annual statement required by March 1, the health maintenance organization shall pay the commissioner the fee for filing ~~its~~ the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed \$5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he considers~~ considered reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ his duties required of the commissioner under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

Section 6. Section 33-31-216, MCA, is amended to read:

"33-31-216. **Protection against insolvency.** (1) Except as provided in subsections (4) through (7),

1 each authorized health maintenance organization shall deposit with the commissioner cash, securities, or
2 any combination of cash or securities acceptable to the commissioner in the amount set forth in this
3 section.

4 (2) The amount of the deposit for a health maintenance organization during the first year of its
5 operation ~~must be the greater of:~~

6 ~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~

7 ~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~

8 ~~(c) \$100,000 is \$200,000.~~

9 (3) At the beginning of each succeeding year, unless not applicable, the health maintenance
10 organization shall deposit with the commissioner cash, securities, or any combination of cash or securities
11 acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures
12 for that year.

13 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
14 1987, shall make a deposit equal to the greater of:

15 (a) 1% of the preceding 12 months' uncovered expenditures; or

16 (b) ~~\$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987.~~
17 ~~In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its~~
18 ~~estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must~~
19 ~~be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and~~
20 ~~subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual~~
21 ~~uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably~~
22 ~~reflect the preceding year's operating experience and delivery arrangements.~~

23 (5) The commissioner may ~~in his discretion~~ waive any of the deposit requirements set forth in
24 subsections (1) through (4) whenever ~~he~~ the commissioner is satisfied that:

25 (a) the health maintenance organization has sufficient net worth and an adequate history of
26 generating net income to ~~assure~~ ensure its financial viability for the next year;

27 (b) the health maintenance organization's performance and obligations are guaranteed by an
28 organization with sufficient net worth and an adequate history of generating net income; or

29 (c) the health maintenance organization's assets or its contracts with insurers, health service
30 corporations, governments, or other organizations are reasonably sufficient to assure the performance of

1 its obligations.

2 (6) When a health maintenance organization achieves a net worth not including land, buildings, and
3 equipment of at least \$1 million or achieves a net worth including organization-related land, buildings, and
4 equipment of at least \$5 million the annual deposit requirement under subsection (3) does not apply. The
5 annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the
6 total amount of the accumulated deposit is greater than the capital requirement for the formation or
7 admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing
8 organization that has been in operation for at least 5 years and has a net worth not including land,
9 buildings, and equipment of at least \$1 million or that has been in operation for at least 10 years and has
10 a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual
11 deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring
12 more than one health maintenance organization, however, the net worth requirement is increased by a
13 multiple equal to the number of ~~such~~ those health maintenance organizations. This requirement to maintain
14 a deposit in excess of the deposit required of a disability insurer does not apply during any time that the
15 guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at
16 least equal to the capital and surplus requirements for a disability insurer.

17 (7) All income from deposits belongs to the depositing health maintenance organization and must
18 be paid to it as it becomes available. A health maintenance organization that has made a securities deposit
19 may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any
20 combination of cash or securities of equal amount and value. A health maintenance organization may not
21 substitute securities without prior approval by the commissioner.

22 (8) In any year in which an annual deposit is not required of a health maintenance organization,
23 at the health maintenance organization's request, the commissioner shall reduce the previously accumulated
24 deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows the health
25 maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth
26 no longer supports a reduction of its required deposit, the health maintenance organization shall immediately
27 redeposit \$100,000 for each \$250,000 of reduction in net worth, ~~except that its.~~ However, the health
28 maintenance organization's total deposit may not be required to exceed the maximum required under this
29 section.

30 (9) Unless it is operated by an insurer or a health service corporation as a plan, each health

1 maintenance organization ~~shall~~ must have a minimum capital of at least \$200,000 in addition to any deposit
2 requirements under this section. The capital account must be in excess of any accrued liabilities and be in
3 the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

4 (10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

5 (a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

6 (b) enrollees will be entitled to similar alternate insurance coverage that does not contain any
7 medical underwriting or preexisting limitation requirements."
8

9 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
10 organization may not increase a premium for an individual's or an individual's group health care services
11 agreement more frequently than once during a 12-month period unless failure to increase the premium more
12 frequently than once during the 12-month period would:

13 (a) place the health maintenance organization in violation of the laws of this state; or

14 (b) cause the financial impairment of the health maintenance organization to the extent that further
15 transaction of insurance by the health maintenance organization would injure or be hazardous to its
16 enrollees or to the public.

17 (2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, by
18 a court decision, by a state rule, or by a federal regulation.
19

20 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
21 Plan Network Adequacy and Quality Assurance Act".
22

23 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

24 (1) establish standards for the creation and maintenance of networks by health carriers offering
25 managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered
26 under a managed care plan by establishing requirements for written agreements between health carriers
27 offering managed care plans and participating providers regarding the standards, terms, and provisions
28 under which the participating provider will provide services to covered persons;

29 (2) provide for the implementation of state network adequacy and quality assurance standards in
30 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for

1 detecting and reporting violations of those standards to the commissioner;

2 (3) establish minimum criteria for the quality assessment activities of a health carrier issuing a
3 closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted
4 by rule;

5 (4) enable health carriers to evaluate, maintain, and improve the quality of health care services
6 provided to covered persons; and

7 (5) provide a streamlined and simplified process by which managed care network adequacy and
8 quality assurance programs may be monitored for compliance THROUGH COORDINATED EFFORTS OF THE
9 COMMISSIONER AND THE DEPARTMENT ~~(AND THE BOARD)~~. It is not the purpose or intent of [sections
10 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
11 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
12 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.
13

14 NEW SECTION. Section 10. Definitions. As used in [sections 8 through 29], the following
15 definitions apply:

16 (1) "Closed plan" means a managed care plan that requires covered persons to use only
17 participating providers under the terms of the managed care plan.

18 (2) "Combination plan" means an open plan with a closed component.

19 (3) "Covered benefits" means those health care services to which a covered person is entitled
20 under the terms of a health benefit plan.

21 (4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating
22 in a health benefit plan.

23 (5) "Department" means the department of public health and human services established in
24 2-15-2201.

25 (6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient
26 severity, including severe pain, that the absence of immediate medical attention could reasonably be
27 expected to result in any of the following:

28 (a) the covered person's health would be in serious jeopardy;

29 (b) the covered person's bodily functions would be seriously impaired; or

30 (c) a bodily organ or part would be seriously damaged.

(7) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(10) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

(11) "Health care provider" or "provider" means a health care professional or a facility.

(12) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(13) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

(14) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

(15) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services, MEDICINES, or supplies that are necessary and appropriate for the DIAGNOSIS OR treatment of a covered person's ~~emergency~~ ILLNESS, INJURY, OR medical condition ~~or for the preventive care of a covered person~~ according to accepted standards of medical practice AND THAT ARE NOT PROVIDED ONLY AS A CONVENIENCE.

(17) "Network" means the group of participating providers that provides health care services to

1 a managed care plan.

2 (18) "Open plan" means a managed care plan other than a closed plan that provides incentives,
3 including financial incentives, for covered persons to use participating providers under the terms of the
4 managed care plan.

5 (19) "Participating provider" means a provider who, under a contract with a health carrier or with
6 the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services
7 to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or
8 deductibles, directly or indirectly from the health carrier.

9 (20) "Primary care professional" means a participating health care professional designated by the
10 health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and
11 who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision
12 of health care services rendered to the covered person.

13 (21) "Quality assessment" means the measurement and evaluation of the quality and outcomes
14 of medical care provided to individuals, groups, or populations.

15 (22) "Quality assurance" means quality assessment and quality improvement.

16 (23) "Quality improvement" means an effort to improve the processes and outcomes related to the
17 provision of health care services within a health plan.

18

19 **NEW SECTION.** **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
20 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
21 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
22 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
23 medicaid recipients.

24

25 **NEW SECTION.** **Section 12. Department -- general powers and duties -- rulemaking.** (1) The
26 department shall:

27 (a) adopt rules pursuant to the Montana Administrative Procedure Act establishing minimum state
28 standards for network adequacy and quality assurance and procedures for ensuring compliance with those
29 standards; and

30 (b) recommend action to the commissioner ~~[OR TO THE BOARD]~~ against a health carrier whose

1 managed care plan does not comply with standards for network adequacy and quality assurance adopted
2 by the department.

3 (2) Quality assurance standards adopted by the department must consist of some but not all of the
4 health plan employer data and information standards. The department shall select and adopt only standards
5 appropriate for quality assurance in Montana.

6 (3) The state may contract, through a competitive bidding process, for the development of network
7 adequacy and quality assurance standards.

8
9 **NEW SECTION. Section 13. Network adequacy -- standards -- access plan required.** (1) A health
10 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
11 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
12 Sufficiency in number and type of provider is determined in accordance with the requirements of this
13 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
14 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
15 may include but are not limited to:

- 16 (a) a ratio of specialty care providers to covered persons;
17 (b) a ratio of primary care providers to covered persons;
18 (c) geographic accessibility;
19 (d) waiting times for appointments with participating providers;
20 (e) hours of operation; or
21 (f) the volume of technological and specialty services available to serve the needs of covered
22 persons requiring technologically advanced or specialty care.

23 (2) Whenever a health carrier has an insufficient number or type of participating providers to
24 provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered
25 benefit at no greater cost to the covered person than if the covered benefit were obtained from participating
26 providers or shall make other arrangements acceptable to the department.

27 (3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable
28 proximity of participating providers to the businesses or personal residences of covered persons. In
29 determining whether a health carrier has complied with this requirement, consideration must be given to
30 the relative availability of health care providers in the service area under consideration.

~~(4) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability, and legal authority of its providers to furnish all covered benefits to covered persons.~~

~~(6)~~(4) A health carrier offering a managed care plan in this state on October 1, ~~1998~~ 1999, shall file with the department on October 1, ~~1998~~ 1999, an access plan complying with subsection ~~(7)~~ (6) and the rules of the department. A health carrier offering a managed care plan in this state for the first time after October 1, ~~1998~~ 1999, shall file with the department an access plan meeting the requirements of subsection ~~(7)~~ (6) and the rules of the department before offering the managed care plan. A plan must be filed with the department in a manner and form complying with the rules of the department. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

~~(6)~~(5) A health carrier may request the department to designate parts of its access plan as proprietary or competitive information, and when designated, that part may not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. A health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the plan upon request.

~~(7)~~(6) An access plan for each managed care plan offered in this state must describe or contain at least the following:

- (a) a listing of the names and specialties of the health carrier's participating providers;
- (b) the health carrier's procedures for making referrals within and outside its network;
- (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in the managed care plan;
- (d) the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
- (e) the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
- (f) the health carrier's method of informing covered persons of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(g) the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians and for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) the health carrier's process for enabling covered persons to change primary care professionals;

(i) the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and a participating provider or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and be transferred to other providers in a timely manner.

(j) any other information required by the department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

(7) THE DEPARTMENT SHALL ENSURE TIMELY AND EXPEDITED REVIEW AND APPROVAL OF THE ACCESS PLAN AND OTHER REQUIREMENTS IN THIS SECTION.

NEW SECTION. Section 14. Provider responsibility for care -- contracts -- prohibited collection practices. ~~(1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, by which a participating provider will be notified on an ongoing basis of the covered health care services for which the participating provider is responsible, including any limitations or conditions on those health care services.~~

~~(2)~~**(1)** A contract between a health carrier and a participating provider must set forth a hold harmless provision specifying protection for covered persons. This requirement is met by including in a contract a provision substantially the same as the following:

"The provider agrees that the provider may not for any reason, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a covered person or a person other than the health carrier or intermediary acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person. This agreement does not prohibit a provider, except a health care professional who

1 is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to
2 that health carrier's covered persons and no others, and a covered person from agreeing to continue
3 services solely at the expense of the covered person if the provider has clearly informed the covered person
4 that the health carrier may not cover or continue to cover a specific service or services. Except as provided
5 in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available
6 for obtaining payment for services from the health carrier."

7 ~~(3)(2)~~ A contract between a health carrier and a participating provider must state that if a health
8 carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered
9 persons will continue through the end of the period for which a premium has been paid to the health carrier
10 on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from
11 an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined
12 in an ACUTE CARE inpatient facility on the date of insolvency or other cessation of operations must be
13 continued by a provider until the confinement in an inpatient facility is no longer medically necessary.

14 ~~(4)(3)~~ The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2)
15 must be construed in favor of the covered person, survive the termination of the contract regardless of the
16 reason for termination, including the insolvency of the health carrier, and supersede an oral or written
17 contrary agreement between a participating provider and a covered person or the representative of a
18 covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered
19 benefits provisions required by subsections ~~(2) and (3)~~ (1) AND (2).

20 ~~(5)(4)~~ A participating provider may not collect or attempt to collect from a covered person money
21 owed to the provider by the health carrier.
22

23 **NEW SECTION. Section 15. Selection of providers -- professional credentials standards.** (1) A
24 health carrier shall adopt standards for selecting participating providers who are primary care professionals
25 and for each health care professional specialty within the health carrier's network. The health carrier shall
26 use the standards to select health care professionals, the health carrier's intermediaries, and any provider
27 network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow
28 the health carrier to:

29 (a) avoid high-risk populations by excluding a provider because the provider is located in a
30 geographic area that contains populations or providers presenting a risk of higher than average claims,

1 losses, or use of health care services; or

2 (b) exclude a provider because the provider treats or specializes in treating populations presenting
3 a risk of higher than average claims, losses, or use of health care services.

4 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
5 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
6 through 21] and the rules implementing [sections 13 through 21].

7 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
8 with which the health carrier or its intermediary contract to employ specific providers or types of providers
9 who may meet their selection criteria or to contract with or retain more providers or types of providers than
10 are necessary to maintain an adequate network.

11 (4) A health carrier may use criteria established in accordance with the provisions of this section
12 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
13 carrier shall make its selection standards for participating providers available for review by the department
14 and by each health care professional who is subject to the selection standards.

15
16 **NEW SECTION. Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering
17 a managed care plan shall notify, in writing, prospective participating providers of the participating
18 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
19 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
20 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
21 requirements.

22 (2) A health carrier may not offer an inducement under a managed care plan to a participating
23 provider to provide less than medically necessary services to a covered person.

24 (3) A health carrier may not prohibit a participating provider from discussing a treatment option
25 with a covered person or from advocating on behalf of a covered person within the utilization review or
26 grievance processes established by the health carrier or a person contracting with the health carrier.

27 (4) A health carrier shall require a participating provider to make health records available to
28 appropriate state and federal authorities, in accordance with the applicable state and federal laws related
29 to the confidentiality of medical or health records, when the authorities are involved in assessing the quality
30 of care or investigating a grievance or complaint of a covered person.

1 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each
2 other before terminating the contract between them without cause. The health carrier shall make a good
3 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
4 notice of termination from or to a participating provider, to all covered persons who are patients seen on
5 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
6 termination is for cause or without cause. If a contract termination involves a primary care professional,
7 all covered persons who are patients of that primary care professional must be notified.

8 (6) A health carrier shall ensure that a participating provider furnishes covered benefits to all
9 covered persons without regard to the covered person's enrollment in the plan as a private purchaser or
10 as a participant in a publicly financed program of health care services. This requirement does not apply to
11 circumstances in which the participating provider should not render services because of the participating
12 provider's lack of training, experience, or skill or because of a restriction on the participating provider's
13 license.

14 (7) A health carrier shall notify the participating providers of their obligation, if any, to collect
15 applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of
16 coverage or of the participating providers' obligations, if any, to notify covered persons of the covered
17 persons' personal financial obligations for noncovered benefits.

18 (8) A health carrier may not penalize a participating provider because the participating provider,
19 in good faith, reports to state or federal authorities an act or practice by the health carrier that may
20 adversely affect patient health or welfare.

21 (9) A health carrier shall establish a mechanism by which a participating provider may determine
22 in a timely manner whether or not a person is covered by the health carrier.

23 (10) A health carrier shall establish procedures for resolution of administrative, payment, or other
24 disputes between the health carrier and participating providers.

25 (11) A contract between a health carrier and a participating provider may not contain definitions
26 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
27 [sections 8 through 29].

28 (12) A contract between a health carrier and a participating provider shall set forth all of the
29 responsibilities and obligations of the provider either in the contract or documents referenced in the
30 contract. A health carrier shall make its best effort to furnish copies of any reference documents, if

1 requested by a participating provider, prior to execution of the contract.

2
3 **NEW SECTION. Section 17. Emergency services.** (1) A health carrier offering a managed care plan
4 shall provide or pay for emergency services screening and emergency services and may not require prior
5 authorization for either of those services. If an emergency services screening determines that emergency
6 services or emergency services of a particular type are unnecessary for a covered person, emergency
7 services or emergency services of the type determined unnecessary by the screening need not be covered
8 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
9 determines that emergency services or emergency services of a particular type are necessary, those
10 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
11 carrier, acting through a participating provider or other authorized representative, has authorized the
12 provision of emergency services.

13 (2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork
14 provider within the service area of a managed care plan and may not require prior authorization of those
15 services if use of a participating provider would result in a delay that would worsen the medical condition
16 of the covered person or if a provision of federal, state, or local law requires the use of a specific provider.

17 (3) If a participating provider or other authorized representative of a health carrier authorizes
18 emergency services, the health carrier may not subsequently retract its authorization after the emergency
19 services have been provided or reduce payment for an item or health care services furnished in reliance on
20 approval unless the approval was based on a material misrepresentation about the covered person's medical
21 condition made by the provider of emergency services.

22 (4) Coverage of emergency services is subject to applicable coinsurance, copayments, and
23 deductibles.

24 (5) For postevaluation or poststabilization services required immediately after receipt of emergency
25 services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a
26 week, to facilitate review.

27
28 **NEW SECTION. Section 18. Use of intermediaries -- responsibilities of health carriers,**
29 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
30 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which

1 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

2 (2) A health carrier may determine whether a subcontracted provider participates in the provider's
3 own network or a contracted network for the purpose of providing covered benefits to the health carrier's
4 covered persons.

5 (3) A health carrier shall maintain copies of all intermediary health care subcontracts at the health
6 carrier's principal place of business in this state or ensure that the health carrier has access to all
7 intermediary subcontracts, including the right to make copies of the contracts, upon 20 days' prior written
8 notice from the health carrier.

9 (4) If required in a contract or otherwise by a health carrier, an intermediary shall transmit utilization
10 documentation and claims-paid documentation to the health carrier. The health carrier shall monitor the
11 timeliness and appropriateness of payments made to providers and health care services received by covered
12 persons. This duty may not be delegated to an intermediary by a health carrier.

13 (5) If required in a contract or otherwise by a health carrier, an intermediary shall maintain the
14 books, records, financial information, and documentation of services provided to covered persons at its
15 principal place of business in the state and preserve them for 5 years in a manner that facilitates regulatory
16 review.

17 (6) An intermediary shall allow the COMMISSIONER AND THE department access to the
18 intermediary's books, records, claim information, billing information, and other documentation of services
19 provided to covered persons that are required by any of those entities to determine compliance with
20 [sections 13 through 21] and the rules implementing [sections 13 through 21].

21 (7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to
22 the health carrier of the provisions of a participating provider's contract addressing the participating
23 provider's obligation to furnish covered benefits.

24
25 **NEW SECTION.** **Section 19. Contract filing requirements -- material changes -- state access to**
26 **contracts.** (1) On October 1, ~~1998~~ 1999, a health carrier offering a managed care plan shall file with the
27 department sample contract forms proposed for use with its participating providers and intermediaries.

28 (2) A health carrier shall file with the department a material change to a contract. The change must
29 be filed with the department at least 60 days before use of the proposed change. A change in a
30 participating provider payment rate, coinsurance, copayment, or deductible or other plan benefit is not

considered a material change for the purpose of this subsection.

(3) A health carrier shall maintain participating provider and intermediary contracts at its principal place of business in this state, or the health carrier must have access to all contracts and provide copies to the department upon 20 days' prior written notice from the department.

NEW SECTION. Section 20. General contracting requirements. (1) The execution of a contract for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty to provide health care services to a person with whom the health carrier has contracted and does not relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules implementing [sections 8 through 29].

(2) All contracts by a health carrier for the provision of health care services by a managed care plan must be in writing and are subject to review by the department and the commissioner.

NEW SECTION. Section 21. Contract compliance dates. (1) A contract between a health carrier and a participating provider or intermediary in effect on October 1, ~~1997~~ 1999, must comply with [sections 13 through 21] and the rules implementing [sections 13 through 21] by ~~April~~ OCTOBER 1, 1999. The department may extend the ~~April~~ OCTOBER 1 date for an additional period of up to 6 months if the health carrier demonstrates good cause for an extension.

(2) A contract between a health carrier and a participating provider or intermediary issued or put into effect on or after ~~April 1, 1998~~ OCTOBER 1, 1999, must comply with [sections 13 through 21] and the rules implementing [sections 13 through 21] on the day that it is issued or put into effect.

(3) A contract between a health carrier and a participating provider or intermediary not described in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections 13 through 21] by ~~April~~ OCTOBER 1, 1999.

NEW SECTION. Section 22. Department rules. The department ~~shall~~ MAY adopt rules to implement [sections 13 through 21].

NEW SECTION. Section 23. Quality assurance -- national accreditation. (1) A health carrier whose managed care plan has been accredited by a nationally recognized accrediting organization shall

1 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
2 organization to the department.

3 (2) If the department finds that the standards of a nationally recognized accrediting organization
4 meet or exceed state standards and that the health carrier has been accredited by the nationally recognized
5 accrediting organization, the department shall approve the quality assurance standards of the health carrier.

6 (3) The department shall maintain a list of accrediting organizations whose standards have been
7 determined by the department to meet or exceed state quality assurance standards.

8 (4) [Section 24] does not apply to a health carrier's managed care plan if the health carrier
9 maintains current accreditation by a nationally recognized accrediting organization whose standards meet
10 or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

11 (5) This section does not prevent the department from monitoring a health carrier's compliance
12 with [sections 23 through 27].
13

14 **NEW SECTION. Section 24. Standards for health carrier quality assessment programs.** A health
15 carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure
16 systems sufficient to accurately measure the quality of health care services provided to covered persons
17 on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this
18 requirement, a health carrier shall:

19 (1) establish and use a system designed to assess the quality of health care provided to covered
20 persons and appropriate to the types of plans offered by the health carrier. The system must include
21 systematic collection, analysis, and reporting of relevant data.

22 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory
23 agencies, providers, and consumers as provided in [section 26];

24 (3) report to the appropriate professional or occupational licensing board provided in Title 37 any
25 persistent pattern of problematic care provided by a participating provider that is sufficient to cause the
26 health carrier to terminate or suspend a contractual arrangement with the participating provider; and

27 (4) file a written description of the quality assessment program and any subsequent material
28 changes with the department in a format that must be prescribed by rules of the department. The
29 description must include a signed certification by a corporate officer of the health carrier that the health
30 carrier's quality assessment program meets the requirements of [sections 23 through 27].

1 **NEW SECTION. Section 25. Standards for health carrier quality improvement programs.** A health
2 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
3 adopt and use systems and methods necessary to improve the quality of health care provided in the health
4 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
5 by this section. To comply with this requirement, a health carrier subject to this section shall:

6 (1) establish an internal system capable of identifying opportunities to improve care;

7 (2) use the findings generated by the system required by subsection (1) to work on a continuing
8 basis with participating providers and other staff within the closed plan or closed component to improve
9 the health care delivered to covered persons;

10 (3) adopt and use a program for measuring, assessing and improving the outcomes of health care
11 as identified in the health carrier's quality improvement program plan. This quality improvement program
12 plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23
13 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program
14 plan within 30 days of implementation of the change. The quality improvement program plan must:

15 (a) implement improvement strategies in response to quality assessment findings that indicate
16 improvement is needed; and

17 (b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to
18 subsection (3)(a).

19
20 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
21 a closed plan or a combination plan shall document and communicate information, as required in this
22 section, about its quality assurance program. The health carrier shall:

23 (a) include a summary of its quality assurance program in marketing materials;

24 (b) include a description of its quality assurance program and a statement of patient rights and
25 responsibilities with respect to that program in the certificate of coverage or handbook provided to newly
26 enrolled covered persons; and

27 (c) make available annually to providers and covered persons a report containing findings from its
28 quality assurance program and information about its progress in meeting internal goals and external
29 standards, when available.

30 (2) A health carrier shall certify to the department annually that its quality assurance program and

1 the materials provided to providers and consumers in accordance with subsection (1) meet the requirements
2 of [sections 23 through 27].

3 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
4 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality
5 requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier
6 shall retain all certified materials for at least 3 years from the date that the material was certified or until
7 the material has been examined as part of a market conduct examination, whichever is later.

8
9 **NEW SECTION. Section 27. Confidentiality of health care and quality assurance records --**
10 **disclosure.** (1) Except as provided in subsection (2), the following information held by a health carrier
11 offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a
12 person:

13 (a) information pertaining to the diagnosis, treatment, or health of a covered person, regardless of
14 whether the information is in the form of paper, is preserved on microfilm, or is stored in
15 computer-retrievable form;

16 (b) information considered by a quality assurance program and the records of its actions, including
17 testimony of a member of a quality committee, of an officer, director, or other member of a health carrier
18 or its staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment,
19 quality improvement, or quality assurance activities, or of any person assisting or furnishing information
20 to the quality committee.

21 (2) The information specified in subsection (1) may be disclosed:

22 (a) as allowed by Title 33, chapter 19;

23 (b) as required in proceedings before the commissioner, a professional or occupational licensing
24 board provided in Title 37, or the department pursuant to Title 50, chapter 5, part 2;

25 (c) in an appeal, if an appeal is permitted, from a quality committee's findings or recommendations;
26 or

27 (d) as otherwise required by law or court order, including a judicial or administrative subpoena.

28 (3) Information specified in subsection (1) identifying:

29 (a) the provider may also be disclosed upon a written, dated, and signed approval of the provider
30 if the information does not identify the covered person;

(b) the covered person may also be disclosed upon a written, dated, and signed approval of the covered person or of the parent or guardian of a covered person if the covered person is a minor and if the information does not identify the provider;

(c) neither the provider nor the covered person may also be disclosed upon request for use for statistical purposes only.

NEW SECTION. Section 28. Enforcement. (1) If the department ~~[OR THE BOARD]~~ determines that a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the department ~~[OR THE BOARD]~~ may recommend corrective action to the health carrier.

(2) ~~The~~ AT THE RECOMMENDATION OF THE DEPARTMENT ~~[OR THE BOARD]~~ THE commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the department ~~[OR THE BOARD]~~;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a reasonable period of time;

(c) the department ~~[OR THE BOARD]~~ demonstrates to the commissioner that a health carrier does not comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 8 through 29] or the rules implementing [sections 8 through 29].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

(a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's application for a certificate of authority; or

(b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part 3.

NEW SECTION. Section 29. Jurisdiction over contract actions. The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

~~NEW SECTION. SECTION 30. DEFINITIONS. AS USED IN SECTIONS 8 THROUGH 29, THE
FOLLOWING DEFINITIONS APPLY:~~

~~(1) "BOARD" MEANS THE BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE
PROVIDED FOR IN SECTION 31.~~

~~(2) "CLOSED PLAN" MEANS A MANAGED CARE PLAN THAT REQUIRES COVERED PERSONS TO
USE ONLY PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

~~(3) "COMBINATION PLAN" MEANS AN OPEN PLAN WITH A CLOSED COMPONENT.~~

~~(4) "COVERED BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH A COVERED
PERSON IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN.~~

~~(5) "COVERED PERSON" MEANS A POLICYHOLDER, SUBSCRIBER, OR ENROLLEE OR OTHER
INDIVIDUAL PARTICIPATING IN A HEALTH BENEFIT PLAN.~~

~~(6) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
ESTABLISHED IN 2-15-2201.~~

~~(7) "EMERGENCY MEDICAL CONDITION" MEANS A CONDITION MANIFESTING ITSELF BY
SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE
MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN ANY OF THE FOLLOWING:~~

~~(A) THE COVERED PERSON'S HEALTH WOULD BE IN SERIOUS JEOPARDY;~~

~~(B) THE COVERED PERSON'S BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR~~

~~(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.~~

~~(8) "EMERGENCY SERVICES" MEANS HEALTH CARE ITEMS AND SERVICES FURNISHED OR
REQUIRED TO EVALUATE AND TREAT AN EMERGENCY MEDICAL CONDITION.~~

~~(9) "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH
CARE SETTING, INCLUDING BUT NOT LIMITED TO A HOSPITAL, MEDICAL ASSISTANCE FACILITY, AS
DEFINED IN 50-6-101, OR OTHER LICENSED INPATIENT CENTER, AN AMBULATORY SURGICAL OR
TREATMENT CENTER, A SKILLED NURSING CENTER, A RESIDENTIAL TREATMENT CENTER, A
DIAGNOSTIC, LABORATORY, OR IMAGING CENTER, OR A REHABILITATION OR OTHER THERAPEUTIC
HEALTH SETTING.~~

~~(10) "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT
ENTERED INTO, OFFERED, OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR,
PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.~~

1 ~~(11) "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN OR OTHER HEALTH CARE~~
2 ~~PRACTITIONER LICENSED, ACCREDITED, OR CERTIFIED PURSUANT TO THE LAWS OF THIS STATE TO~~
3 ~~PERFORM SPECIFIED HEALTH CARE SERVICES CONSISTENT WITH STATE LAW.~~

4 ~~(12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR~~
5 ~~A FACILITY.~~

6 ~~(13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION,~~
7 ~~TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.~~

8 ~~(14) "HEALTH CARRIER" MEANS AN ENTITY SUBJECT TO THE INSURANCE LAWS AND RULES~~
9 ~~OF THIS STATE THAT CONTRACTS, OFFERS TO CONTRACT, OR ENTERS INTO AN AGREEMENT TO~~
10 ~~PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE~~
11 ~~SERVICES, INCLUDING A DISABILITY INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH~~
12 ~~SERVICE CORPORATION OR ANOTHER ENTITY PROVIDING A HEALTH BENEFIT PLAN.~~

13 ~~(15) "INTERMEDIARY" MEANS A PERSON AUTHORIZED TO NEGOTIATE, EXECUTE, AND BE A~~
14 ~~PARTY TO A CONTRACT BETWEEN A HEALTH CARRIER AND A PROVIDER OR BETWEEN A HEALTH~~
15 ~~CARRIER AND A NETWORK.~~

16 ~~(16) "MANAGED CARE PLAN" MEANS A HEALTH BENEFIT PLAN THAT EITHER REQUIRES OR~~
17 ~~CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR A COVERED PERSON TO USE HEALTH~~
18 ~~CARE PROVIDERS MANAGED, OWNED, UNDER CONTRACT WITH, OR EMPLOYED BY A HEALTH~~
19 ~~CARRIER, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS~~
20 ~~OPERATED IN A FEE FOR SERVICE INDEMNITY ENVIRONMENT.~~

21 ~~(17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND~~
22 ~~APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR~~
23 ~~FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF~~
24 ~~MEDICAL PRACTICE.~~

25 ~~(18) "NETWORK" MEANS THE GROUP OF PARTICIPATING PROVIDERS THAT PROVIDES HEALTH~~
26 ~~CARE SERVICES TO A MANAGED CARE PLAN.~~

27 ~~(19) "OPEN PLAN" MEANS A MANAGED CARE PLAN OTHER THAN A CLOSED PLAN THAT~~
28 ~~PROVIDES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR COVERED PERSONS TO USE~~
29 ~~PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

30 ~~(20) "PARTICIPATING PROVIDER" MEANS A PROVIDER WHO, UNDER A CONTRACT WITH A~~

~~HEALTH CARRIER OR WITH THE HEALTH CARRIER'S CONTRACTOR, SUBCONTRACTOR, OR INTERMEDIARY, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED PERSONS WITH AN EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE, COPAYMENTS, OR DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE HEALTH CARRIER.~~

~~(21) "PRIMARY CARE PROFESSIONAL" MEANS A PARTICIPATING HEALTH CARE PROFESSIONAL DESIGNATED BY THE HEALTH CARRIER TO SUPERVISE, COORDINATE, OR PROVIDE INITIAL CARE OR CONTINUING CARE TO A COVERED PERSON AND WHO MAY BE REQUIRED BY THE HEALTH CARRIER TO INITIATE A REFERRAL FOR SPECIALTY CARE AND TO MAINTAIN SUPERVISION OF HEALTH CARE SERVICES RENDERED TO THE COVERED PERSON.~~

~~(22) "QUALITY ASSESSMENT" MEANS THE MEASUREMENT AND EVALUATION OF THE QUALITY AND OUTCOMES OF MEDICAL CARE PROVIDED TO INDIVIDUALS, GROUPS, OR POPULATIONS.~~

~~(23) "QUALITY ASSURANCE" MEANS QUALITY ASSESSMENT AND QUALITY IMPROVEMENT.~~

~~(24) "QUALITY IMPROVEMENT" MEANS AN EFFORT TO IMPROVE THE PROCESSES AND OUTCOMES RELATED TO THE PROVISION OF HEALTH CARE SERVICES WITHIN A HEALTH PLAN.~~

~~NEW SECTION. SECTION 31. BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE.~~

~~(1) THERE IS A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE. THE BOARD IS COMPOSED OF A MEDICAL DIRECTOR, THE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, PROVIDED FOR IN 2-15-2201, AND THE COMMISSIONER OF INSURANCE, PROVIDED FOR IN 2-15-1903.~~

~~(2) THE MEDICAL DIRECTOR IS APPOINTED BY THE GOVERNOR AND MUST BE LICENSED AS A PHYSICIAN BY THE STATE OF MONTANA. THE MEDICAL DIRECTOR MUST BE A SPECIALIST IN EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

~~(3) THE GENERAL POWERS AND DUTIES OF THE BOARD ARE PROVIDED IN [SECTION 32].~~

~~(4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT PURSUANT TO 2-15-121.~~

~~NEW SECTION. SECTION 32. BOARD - GENERAL POWERS AND DUTIES. THE BOARD SHALL:~~

~~(1) PERIODICALLY REVIEW THE STATE NETWORK ADEQUACY AND QUALITY ASSURANCE~~

~~STANDARDS PROVIDED IN [SECTIONS 8 THROUGH 29] AND THE RULES IMPLEMENTING [SECTIONS 8 THROUGH 29];~~

~~(2) RECOMMEND CORRECTIVE ACTION NECESSARY FOR THE HEALTH CARRIER TO ACHIEVE COMPLIANCE WITH STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS; AND~~
~~(3) RECOMMEND ACTION TO THE COMMISSIONER AGAINST A HEALTH CARRIER WHOSE MANAGED CARE PLAN DOES NOT COMPLY WITH STANDARDS FOR NETWORK ADEQUACY AND QUALITY ASSURANCE ADOPTED BY THE BOARD.~~

NEW SECTION. Section 30. Codification instruction. (1) [Section 7] is intended to be codified as an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

(2) [Sections 8 through ~~29-32 29~~] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 8 through ~~29-32 29~~].

NEW SECTION. Section 31. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 32. Applicability. [This act] applies to a health carrier as defined in [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of this section].

NEW SECTION. Section 33. Effective dates. (1) Except as provided in subsections (2) and (3), [this act] is effective January 1, 1998.

(2) [Sections ~~12, 22, and 30 through 32, 33 THROUGH 35, AND 37 AND 30 THROUGH 32~~ and this section] are effective on passage and approval.

(3) [Sections ~~13, 15, 18 THROUGH 21, AND 23 through 26 29~~] are effective October 1, 1999.

~~(4) [SECTIONS 30 THROUGH 32] AND THE LANGUAGE IN BRACKETS IN [SECTIONS 9, 12, AND 28] ARE EFFECTIVE JULY 1, 2001.~~

1 ~~NEW SECTION. SECTION 37. TERMINATION. [SECTION 10] TERMINATES JUNE 30, 2001.~~

2 -END-